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OBSERVATIONS ON OBSTRUCTED BREATHING.

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RESISTANCE to breathing is an interesting and important subject of investigation. In pathological conditions obstruction rarely occurs. Since the introduction of anti-diphtheritic serum, obstruction of the trachea is much less common than formerly, while other conditions causing obstruction, such as tumours, foreign bodies and syphilitic and tuberculous strictures in the upper part of the respiratory tract, are rare. Of greater interest at the present time, however, are the physiological changes which take place during and after the use of respirators and gas-masks, and for this reason the type of resistance which occurs in gas-masks has been used in the experiments described below. But besides influencing breathing, obstruction to respiration, whether during inspiration or expiration, throws a strain upon the circulation and affects the gaseous exchange within the lungs.

TECHNIQUE.

In any investigation of this phenomenon the subject has to be under basal conditions, care being taken to ensure sufficient rest before the test. As may be seen from the diagram (Figure I), a mouthpiece connects the subject with a valve, the inlet of which consists of a glass tube 1·5 inches in length and four or six millimetres in diameter, inserted through a rubber stopper, while the outlet is connected by a length of rubber tubing one inch in diameter with a rubber bag (football bag). Another piece of rubber tubing of similar diameter leads from the opposite end of the bag, and into this a small side tube is inserted for the collection of samples. The purpose of the bag is to secure complete mixing of the expired air so as to avoid the obtaining of samples from one phase of expiration only.

The exact moment at which an air sample was taken was recorded by means of an electric signal. The respiratory rate was also recorded on the kymograph by leading a piece of tubing from the exit tube of the bag to a Brodie's bellows. Finally, the exit tube led to a gas-meter which offered only a slight resistance to expiration. This gas-meter permitted electrical recording of the expired volume on the Palmer's kymograph. Thus the respiration rate, the minute volume of expired air and expired air samples were simultaneously recorded.

In this series of experiments only obstructed inspiration was studied. One of the reasons for using this kind of obstruction is the fact that modern gas-masks have filters, offering a certain resistance only on the inspiratory side. In the first series of tests the effect of exercise upon oxygen

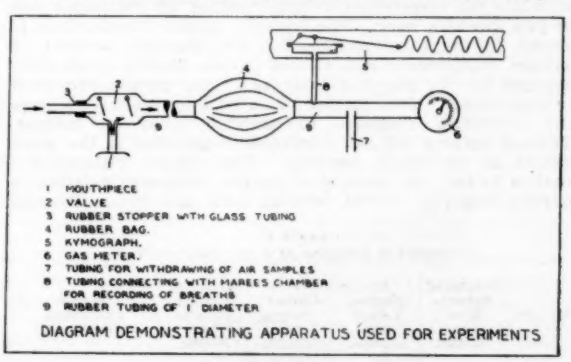

FIGURE I.

consumption and carbon dioxide production in healthy subjects was studied. Secondly, the influence of inspiratory obstruction upon the same subjects during rest and during exercise was investigated. Finally, patients suffering from congestive heart failure, compensated and decompensated, were subjected to the obstruction test, but only at rest, and by means of the six millimetre obstruction.

The exercise consisted of 30 knee-bendings performed within about one minute. Simonson and Gollwitzer-Meyer hold the opinion that knee-bending exercises for respiratory experiments have the advantage of testing the mechanical efficiency of the subject as a whole, including individual factors such as body weight, circulation *et cetera*.

TABLE I.

The Effects of Exercise without Obstruction to Breathing.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litres of Oxygen per Minute.	Litres of Carbon Dioxide per Minute.	Oxygen Utilization (Percentage.)	
1	17	11·5	—	—	—	Rest period.
2	17	11·0	0·27	0·2	13·2	
3	26	20·0	0·94 1·27	0·63 0·97	25·0 33·6	Knee-bending.
4	23	25·5	0·86	0·90	18·35	Recovery period.
5	20	21·0	0·55	0·56	14·2	
6	19	15·0	—	—	—	
7	18	13·0	0·40	0·34	16·6	

The first sample of expired air was taken during the resting period, the second two minutes after insertion of the obstructing glass tube, the third after 15 knee-bendings, the fourth after another 15 knee-bendings. Two samples were then taken after the first and second minutes of the recovery period, and a last sample was taken as soon as it was obvious that the respiratory volume had nearly returned to normal, usually four minutes after completion of the exercise.

EXPERIMENTAL INVESTIGATION.

Only typical experiments are described out of a large series yielding corresponding figures.

Normal Subjects.

Exercise Test.

A plain exercise test is illustrated in Table I. It can be seen how the oxygen intake rises during exercise and reaches its peak either in the second half of the exercise or in the first minute of the recovery period. The carbon dioxide production reaches its maximum usually in the first minute of the recovery period, a little later than the maximum oxygen consumption. The oxygen debt has usually disappeared three to four minutes after the end of the exercise. The respiratory rate is increased during the second half of the exercise or during the minute following it, while the respiratory volume reaches its maximum one or two minutes later. The highest oxygen consumption is shown in the third sample, but the absolute amount of oxygen requirement and also of carbon dioxide production depends on the physical training of the person subjected to experiment. Even during these tests on normal subjects the individual response to exercise could be noticed. Trained persons did not accelerate respiration to the same extent as untrained persons. The oxygen utilization—that is to say, the amount of oxygen consumed relative to oxygen inspired—varied between 12% and 40%. Persons showing slow respiration had a higher utilization of oxygen, while those who showed rapid and more shallow breathing exhibited a smaller utilization. The increase in respiratory rate could not be related to an increased carbon dioxide production.

TABLE II.

Obstruction to Breathing by a Six-Millimetre Tube.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litres of Oxygen per Minute.	Litres of Carbon Dioxide per Minute.	Oxygen Utilization. (Percentage.)
1	12	7·5			
2	12	8·0	0·48	0·38	32+6 millimetre tube obstruction.
3	11	9·0			
4	10	7·5	0·43	0·33	30·2
5	10	8·0			
6	10	7·5	0·40	0·36	27·8
7	11	7·5			
8	10	7·5	0·47	0·36	32·1

Obstruction Tests.

Obstruction During Rest.—Table II shows the results of a typical test with the six-millimetre glass tube, and Table III the results of a test with the four-millimetre glass tube. The reaction to a six-millimetre tube obstruction was not always uniform. Generally, no great increase of oxygen utilization could be observed; respiration was slowed in nearly every case, the volume being maintained at the same or at a slightly higher level. As long as the volume remained constant, no great change in oxygen utilization could be noticed. Table IV illustrates the effect

TABLE III.

Trained Subject. Obstruction to Breathing by Four-Millimetre Tube.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litres of Oxygen per Minute.	Litres of Carbon Dioxide per Minute.	Oxygen Utilization. (Percentage.)
1	11	7·5			
2	12	8·0	0·41	0·33	27·3+4 millimetre tube obstruction.
3	9	9·0			
4	9	8·5			
5	10	9·0	0·56	0·43	32·4
6	10	9·0			
7	8	9·0	0·43	0·37	24·7
8	8	8·0	0·43	0·39	27·8

TABLE IV.

Untrained Subject. Obstruction to Breathing by Four-Millimetre Tube.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litre of Oxygen per Minute.	Litre of Carbon Dioxide per Minute.	Oxygen Utilization. (Percentage.)
1	17	8·8			
2	18	9·2	0·43	0·27	25·3+4 millimetre tube obstruction.
3	16	9·8	0·31	0·25	16·6
4	15	9·0	0·35	0·26	20·0
5	14	8·0			
6	13	8·0	0·30	0·24	19·6

of a four-millimetre tube obstruction on a healthy but untrained person who was quite unaware of the insertion of the obstructing tube or of the conditions of the experiment. In this test the psychological factor could be clearly demonstrated. In the first minute after insertion of the obstruction, the respiratory volume and depth increased, while the respiration rate increased. The air sample taken after the insertion of the obstruction showed a decrease of oxygen utilization because of the increased respiratory volume. In spite of the fact that the patient was unaware that a tube had been inserted, the obstruction produced an immediate sense of suffocation, which, in its turn, induced mental excitement and anxiety, thereby altering the rate and depth of respiration. The carbon dioxide production was not increased; any increase in the alveolar carbon dioxide tension would, as Haldane and Priestley have shown, increase the depth but not the frequency of respiration. In this case (Table IV) increased respiratory rate was due to mental excitement. Table III demonstrates the effect of a four-millimetre obstruction upon a trained person expecting such an obstruction. In this case the oxygen utilization rose immediately along with slowing of respiration. It may be observed that, whereas in a trained person the respiratory volume increases and the oxygen utilization rises, in the untrained person the respiratory volume remains practically unchanged while the oxygen utilization falls. The relationship between respiratory rate, respiratory volume and oxygen utilization is clearly demonstrated.

Obstruction During Exercise.—Typical experiments, showing the influence of a six-millimetre tube obstruction during exercise, must now be considered. Only a six-millimetre glass tube could be applied, as one of a diameter of four millimetres did not permit of the performance of 30 knee-bendings without a pronounced feeling of suffocation. Table V shows the figures obtained in two experiments, the subject of which was a trained athlete.

TABLE V.

Results after Thirty Knee-bendings. A. With Six-Millimetre Tube Obstruction to Breathing. B. Plain Test, Same Subject.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litres of Oxygen per Minute.	Litres of Carbon Dioxide per Minute.	Oxygen Utilization.
A. With Obstruction to Breathing by Six-Millimetre Tube.					
1	13	9·5			
2	13	8·0	0·36	0·31	20·0←6 millimetre tube obstruction.
3	11	8·5			
4	15	13·5	0·42	0·31	26·1 ←30 knee-
5	20	22·5	0·75 1·50	0·55 0·99	29·4 bendings. 38 →
6	13	22·5	1·03	1·05	24·6
7	12	15·0	0·58	0·65	20·8
8	13	14·0			
9	13	13·0	0·50	0·49	20·6
B. Plain Test.					
1	12	8·5			
2	16	8·5	0·41	0·28	25·1
3	22	20·0	0·87 1·19	0·48 0·80	30·0←30 knee- 30·8 bendings. →
4	15	24·0	0·96	1·05	21·0
5	13	17·0	0·60	0·69	18·0
6	12	12·0			
7	11	11·0	0·37	0·42	18·0

The plain exercise test showed the normal increase of oxygen consumption and carbon dioxide production at the expected moment and a very quick recovery. The oxygen utilization rose to 30% during exertion and returned quickly to or below the normal value. While the subject was breathing through the obstruction, oxygen consumption rose slowly after the beginning of the exercise and reached a maximum towards the end of it. The rise in respiratory volume was slow, and the respiratory volume remained greater in the recovery period. The oxygen debt was not covered within the same time as in the test without obstruction. Because of the relatively smaller respiratory volume, the oxygen utilization was greater. During the recovery period this oxygen utilization remained somewhat higher. Table VI shows how on different days, in spite of the difference in the rate of respiration, the initial respiratory volume remained the same and with this the oxygen utilization. The subject

TABLE VI.

Results after Thirty Knee-bendings. A. With Six-Millimetre Tube Obstruction to Breathing. B. Plain Test (Same Subject, Untrained).

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litres of Oxygen per Minute.	Litres of Carbon Dioxide per Minute.	Oxygen Utilization. (Percentage.)
A. With Obstruction to Breathing by Six-Millimetre Tube.					
1	16	8·0	0·37	0·24	23·8←6 millimetre tube obstruction.
2	13	8·0			
3	12	7·5	0·37	0·21	25·5 ←30 knee-
4	19	15·5	1·18	0·56	39·5 bendings.
5	10	19·0	1·30	0·90	35·3→
6	17	23·6	1·07	1·26	24·7
7	15	17·0	0·60	0·78	18·8
8	13	13·0			
9	14	12·0	0·42	0·47	18·5
B. Plain Test (Same Subject, Untrained).					
1	18	8·5	0·35	0·24	21·5
2	20	11·5	0·63	0·42	28·4 ←30 knee-
3	21	25·0	1·73	1·07	35·6 bendings
4	19	25·0	0·90	1·19	19·3
5	17	18·0	0·52	0·74	15·4
6	18	17·0			
7	17	13·0			
8	19	13·0	0·26	0·42	12·4

of this experiment, being untrained, could not augment the respiratory volume in the same manner as the subject of the preceding experiment, and therefore a quicker increase of oxygen utilization took place. Table VII gives the figures obtained from a person trained in the conditions of the experiments. They are shown only in order to demonstrate how the same exercise can be performed with a relatively small respiratory volume and with a high utilization of oxygen. This person was free from any psychological disturbance, but kept on breathing quietly, obtaining the oxygen requirement with a small number of breaths per minute and a small respiratory volume. A series of experiments yielded the same results. Untrained persons had on the average a greater respiratory volume and a lower oxygen utilization and showed irregular respiration and breaths of variable depth. They were never free from a feeling of suffocation. Thiel has shown how the respiratory mid-position changes in obstructed respiration. He demonstrates that this change is due, not only to obstruction, but to a number of psychic factors,

TABLE VII.

Trained Subject. Thirty Knee-bendings with Six-Millimetre Tube Obstruction to Breathing.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litres of Oxygen per Minute.	Litre of Carbon Dioxide per Minute.	Oxygen Utilization. (Percentage.)
1	11	4·3			
2	11	4·4			
3	10	5·3	0·20	0·12	23·8—6 millimetre tube obstruction.
4	10	6·0			
5	8	5·5	0·30	0·21	28·8
6	8	6·5			
7	14	12·0	0·86	0·53	37·3—30 knee-bendings.
8	14	16·0	1·23	0·83	39·6
9	11	15·0	0·82	0·83	29·0
10	11	11·0	0·41	0·49	19 9
11	11	9·0			
12	9	6·5			
13	11	7·0	0·37	0·28	27·6

Morawitz and Siebeck demonstrated that this change in the respiratory mid-position occurred before any change appeared in the alveolar carbon dioxide tension. Therefore, this change cannot be dependent upon the Hering-Breuer reflex only, as might be supposed. Bittorf and Forschbach brought forward more evidence in favour of a psychic cause for such a change, as they succeeded in demonstrating that any change in the respiratory mid-position was absent in comatose or narcotized patients.

Comment.

In most of our experiments one fact was obvious—namely, the greater increase of absolute oxygen consumption in obstruction experiments in spite of the same amount of exertion. This can be explained by the extra muscular work due to resistance to breathing. Haldane and Priestley found that a rise of alveolar carbon dioxide percentage was associated with resistance to breathing. Liljestrand and Rohrer assume that the oxygen consumption of the respiratory muscles during rest is very low. The increased flow of blood to the heart and lungs due to an increased negative intrathoracic pressure, and hence the increased work of the heart, can possibly be regarded as a reason for a rise in oxygen consumption.

The experiments show that trained and disciplined persons have a more economic respiration than nervous and excitable subjects. This result is of importance in connexion with the use of gas-masks or respirators, as has already been stressed by Haldane and Priestley. Everybody who has to use a gas-mask or a respirator should, therefore, be instructed to breathe deeply, to expire sufficiently (avoiding hyperventilation) and not to yield to any desire to inspire as soon as a feeling of suffocation occurs. If the subject yields to the desire, the respiratory mid-position will be altered and it will be impossible to maintain a high minute volume with a small number of respirations. In the usual circumstances in which masks are used in warfare, it is not to be expected that they will be worn under resting conditions, since people have to perform work (walk, carry stretchers *et cetera*), and therefore more carbon dioxide has to be eliminated. Hence people should be trained to become accustomed to any feeling of suffocation and shown how to overcome it.

Subjects Suffering from Congestive Heart Failure.

It has been shown that under resting conditions resistance to breathing as caused by a six-millimetre tube does not influence oxygen consumption, but augments oxygen utilization in a certain number of cases if the minute volume falls. How the same resistance to breathing influences a patient suffering from slight decompensation due to congestive heart failure, may be seen from Table VIII. This table shows that the respiratory rate increases, but oxygen utilization falls. We have seen that a decrease in respiratory volume will necessarily mean a rise in oxygen utilization in a healthy subject if the oxygen saturation of the arterial blood is to be maintained. But just the contrary happens in cases of congestive heart failure. We see how the utilization falls from 24% to 17% and then rises slightly again; we see the decrease of oxygen consumption per minute and also the decrease of carbon dioxide production in spite of the additional muscular effort required by breathing through obstruction. This case illustrates how heart failure, even with only slight decompensation, responds to resistance to breathing. This patient would not be able to perform any exercise while using a respirator, but would be disabled after a short time.

TABLE VIII.

Heart Failure, Slight Decompensation. Six-Millimetre Tube Obstruction to Breathing.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute.	Litre of Oxygen per Minute.	Litre of Carbon Dioxide per Minute.	Oxygen Utilization. (Percentage.)
1	25	10·0			
2	26	9·0	0·48	0·32	24·6 6 millimetre tube obstruction.
3	22	9·0	0·30	0·27	17·3
4	23	9·0	0·35	0·26	20·0
5	22	9·0	0·37	0·26	21·2

The findings in a case of hypertension without decompensation are illustrated in Table IX. Here the normal response can be shown. Decrease in respiratory volume is followed by a high oxygen utilization, which returns to the initial figures as soon as the volume rises again.

From our experiments it appears as if in decompensation the relationship between respiratory volume, oxygen intake and oxygen utilization is disturbed.

TABLE IX.

Hypertension, No Decompensation Six-Millimetre Tube Obstruction to Breathing.

Minutes.	Number of Respirations per Minute.	Respiratory Volume per Minute	Litre of Oxygen per Minute.	Litre of Carbon Dioxide per Minute.	Oxygen Utilization. (Percentage.)
1	20	6·5	0·28	0·17	22·0
2	21	6·0			26·0
3	20	6·0	0·31	0·16	26·3
4	22	6·0	0·34	0·19	26·6
5	23	6·5	0·29	0·17	22·8

SUMMARY.

1. In normal subjects a six-millimetre tube obstruction to breathing causes no obvious change in oxygen consumption, oxygen utilization and carbon dioxide production under resting conditions. A four-millimetre tube obstruction produces a slight increase in oxygen utilization.

2. A six-millimetre tube obstruction to breathing during exertion brings about a higher oxygen utilization in persons with economical respiration. A relationship between minute volume and oxygen utilization can be demonstrated. Training and discipline are regarded as essential for wearers of gas-masks and respirators.

3. In cases of heart failure in which slight decompensation is present, a six-millimetre tube obstruction to breathing at rest causes no increase of oxygen utilization despite decrease of the minute volume.

ACKNOWLEDGEMENTS.

I wish to thank Professor C. G. Lambie for the help and encouragement he has given me throughout these investigations, and for his hospitality in placing all the facilities of his department at my disposal.

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DERMATITIS FOLLOWING THE LOCAL APPLICATION OF SULPHANILAMIDE.

By B. FISHER, M.D. (Vienna),
Captain, Australian Army Medical Corps.

DURING the past eighteen months a large number of adverse reactions following the local application of sulphanilamide have been diagnosed and treated in the dermatological wards. The patients examined by me were sent for consultation or treatment by regimental aid posts, field ambulances and camp hospitals in an operational area. The lesions, which had been treated locally with sulphanilamide powder or ointment, comprised minor burns, abrasions, lacerations, furuncles and various types of ulcers. As the number of these cases of dermatitis dealt with now exceeds 100, permission was asked of the officer commanding, medical division, to conduct an investigation, and to establish the importance of sulphanilamide preparations in their causation.

At the time of the investigation twelve patients were available, all of whom were suffering from local or general dermatitis apparently caused by sulphanilamide powder or ointment. Four aspects of the condition were studied: (i) history of the patient, (ii) appearance of the skin lesions, (iii) reactions to a skin test, and (iv) reactions to the oral administration of sulphanilamide.

History.

The history was remarkably similar in all the cases investigated. In every case sulphanilamide had been applied locally to a lesion for at least three days. After a period of two to four days the patient noted itching and irritation around the treated area. In eight of the twelve cases this itching and irritation became generalized. The parts mainly affected were the face, neck, chest, abdomen and flexor surfaces generally, in particular the flexures (axilla, intercrural region, popliteal and cubital fossæ). The patient complained of irritability and of difficulty in sleeping, with a slight constant headache and some degree of anorexia. These symptoms accompanied the outbreak of the rash and were not due to the lesion treated, which in several cases had practically cleared before sulphanilamide powder was applied to "dry it up".

Appearance of the Rash.

On the skin in the region of the lesion treated an erythemato-papular rash developed. This soon became exudative, weeping freely. The lesion itself, although nearly healed in several cases, broke down and became covered with a sero-purulent exudate. In eight cases a general rash developed, consisting of areas of erythemato-papular eruption situated on the face, neck, chest, abdomen and forearms, and in the axillæ, intercrural region, and cubital and popliteal fossæ. The rash on the forearms was accompanied by a considerable degree of œdema of the wrists and hands in some cases.

Treatment.

The main treatment given was immediate suspension of the sulphanilamide applications, together with the use of local applications to ease the irritation. (See appendix for details.) All patients under this treatment improved greatly in twenty-four hours and were completely well in one or two weeks.

Skin Tests.

Scratch tests were made to prove that the patients were sensitive to sulphanilamide powder. These tests were made after the rash and all symptoms had subsided. Twelve patients were tested.

The skin of the forearm was cleaned with ether. Four scratches were made with a sterile scalpel in a cross-hatch design. Sulphanilamide powder was dusted over the scratches and the area was sealed off with "Cellophane" and adhesive plaster. The tests were read in twelve hours and twenty-four hours.

In twelve hours, two of the patients had reacted so severely that the sulphanilamide powder was removed. These two patients showed a local and general reaction. The other ten patients showed a local reaction after twenty-four hours. The powder was then removed from all ten and the skin was cleaned with spirit. Four of these ten developed a generalized papular rash in the next twenty-four hours on the previously affected areas.

Descriptions of the Lesions Resulting from the Skin Tests.

The local reaction from the skin tests was as follows. The scratches themselves were red and upraised and exuded serum. An erythemato-papular rash formed a patch about two inches square around the marks, and the skin in that area was swollen and red. The patient complained of an itching and burning sensation in the test area.

A general reaction was experienced by six of the twelve patients tested. Generalized erythema occurred with a sensation of burning and itching over the whole body. The exposed parts were particularly affected. Areas of maculo-papular rash appeared on the arms, body and face, and in addition in some cases the face was swollen and the hands were œdematous. In four cases the original erythemato-papular rash broke out again with a return of the previous symptoms. In five cases the already healed lesions (originally treated with sulphanilamide) became inflamed again and exuded seropurulent material.

All these local and general reactions subsided again in one or two days after the sulphanilamide powder had been carefully removed from the skin.

Reactions to the Oral Administration of Sulphanilamide.

Eight of the twelve patients were given 0·5 gramme of sulphanilamide in tablet form by mouth when all the scratch test symptoms had subsided. The four patients who had reacted severely to the skin test were excluded. The patients were not informed of the nature of the tablet.

Between four and eight hours after ingestion of the sulphanilamide, four patients again developed a general reaction similar to the one described as following the scratch test. None of the patients complained of nausea or vomiting. Three of the four remaining patients developed a reaction on the previously affected skin, as well as on the area of the previous scratch test. The scratches themselves became raised and white and exuded serum. In the other areas which had been affected by the original rash papular patches once more developed. Generalized itching and irritation were present. One patient showed no local or general rash, but complained of sleeplessness caused by a generalized irritation of the skin.

Conclusion.

As the 100 patients mentioned above exhibited similar symptoms, had similar histories and also responded similarly to the same treatment as the twelve patients tested, it is concluded that those patients were suffering from dermatitis due to sulphanilamide sensitivity.

In a recent article in the *British Medical Journal*,[1] Park describes twelve cases in which skin lesions were treated with sulphanilamide powder, the patients subsequently reacting severely to the oral administration of sulphanilamide and other sulphonamides. He concluded that these patients had been sensitized to the drugs by the previous skin treatment.

In view of the danger of this induced sensitivity, it is all the more desirable to limit the use of sulphanilamide powder and ointment to cases in which it is indicated.

Recommendations.

1. Applications containing sulphanilamide should not be used for skin conditions except when they are indicated with certainty.
2. When such applications are used, the patient should be carefully watched by the medical officer, and the treated area should be inspected every day for signs of adverse reactions.
3. When a local or general reaction occurs, the use of the sulphanilamide preparation should be discontinued immediately.

Acknowledgement.

My thanks are due to Lieutenant-Colonel R. Binns, Officer Commanding, Medical Division, of an Australian general hospital, for permission to investigate and report these cases, and to Captain L. Rail for his valuable assistance. This report is published by permission of the Director-General of Medical Services, Major-General S. R. Burston.

Reference.

[1] R. G. Park: "Cutaneous Hypersensitivity to Sulphonamides: Report of Twelve Cases", *British Medical Journal*, July 17, 1943, page 69.

Appendix.

The following treatment was given in cases of dermatitis caused by sulphanilamide:

1. Weeping areas were painted daily with a 5% solution of silver nitrate.
2. All other affected areas were painted daily with a 1% alcoholic solution of gentian violet.
3. Eusol compresses were applied every four hours to areas where the papular rash was completely developed.
4. Skin areas affected by itch and erythema only were treated with zinc cream and a 1% solution of phenol.

Reports of Cases.

A CASE OF ABSENCE OF THE GALL-BLADDER.

By KEITH J. B. DAVIS,
Tamworth, New South Wales.

Clinical Record.

MRS. J.E.W., aged fifty-six years, was examined at her home on January 26, 1944, complaining of pain in the abdomen of five days' duration. The pain was continuous; she was nauseated, but had not vomited. Her appetite was poor; food did not affect the pain. Her bowels had been well opened that day. There was no frequency of micturition and no scalding. She had no cough and was not dyspnœic.

On examination, the patient was seen to be a small, spare woman, lying comfortably in bed. The temperature was 98·4° F., the pulse rate was 70 per minute, and respirations numbered 18 per minute. She was not jaundiced, but tenderness without rigidity was present over the right hypochondrium. Murphy's sign was present, but no mass was found. No abnormality was detected in the other systems. The urine contained no abnormal constituents.

The patient was given "Veracolate", one tablet three times per day, and *Mistura Acidi Acetylsalicylici Composita* (Australian Pharmaceutical Formulary) every four hours. Thirteen days later she was a little better, and was able to travel five miles by car to seek further medical treatment. The pain and tenderness were still present.

After her admission to hospital, a fractional test meal examination revealed that the fasting gastric juice measured 26 cubic centimetres; there was no free acid in any specimen. The total acid figure for the fasting juice was equivalent to ten cubic centimetres of N/10 caustic soda; half an hour later the figure was five cubic centimetres, and after one hour it was ten cubic centimetres. No blood or lactic acid was found, but mucus was present in excess in each specimen. Bile was found in the fasting juice only. A cholecystogram gave the following findings. What appeared to be the gall-bladder was abnormal and irregular in shape, and the presence of a calculus was suspected. Dye passed through to the large bowel.

On February 16 laparotomy was performed under anæsthesia induced by ether administered by the intrapharyngeal route, 5·25 drachms of paraldehyde being given *per rectum* and 1/100 grain of atropine sulphate hypodermically. A complete search was made for the gall-bladder, which was not visible. Examination of the *porta hepatis* failed to reveal any sign of a cystic duct. The liver was normal and palpation revealed no sign of an intrahepatic gall-bladder. The stomach, duodenum and pancreas were normal. No calculus was palpable in the common bile duct. The abdomen was closed without drainage; a Clark's retention enema was given and the patient was returned to the ward in good condition. Convalescence was uninterrupted.

Discussion.

The case is reported on account of its rarity. Abnormality of the bile and cystic ducts is frequent—indeed, it is said to be found at 10% of all autopsies.[1] Up to the end of 1941, Gordon and Dragutsky reported upon sixty cases of absence of the gall-bladder; in twenty of these, other abnormalities besides absence of the gall-bladder and cystic duct were present.

Inability to discover the gall-bladder may result from several causes. The first is previous removal; this is excluded in the present case, as there was no scar from a previous upper abdominal operation. The second cause is atrophy of the gall-bladder and burial in adhesions, due to repeated attacks of cholecystitis; no adhesions of consequence were found in the abdomen. The third cause is the presence of an intrahepatic gall-bladder. In the present case the liver was completely examined and palpated; no mass was discernible. The fourth cause is congenital absence of the gall-bladder.

Conclusion.

The importance of this case is that it reveals a fallacy in the cholecystogram and suggests that hepatitis may sometimes be mistaken for cholecystitis.

Reference.

[1] W. C. Gordon and D. Dragutsky: "Congenital Absence of the Gall Bladder and Cystic Duct", *The Journal of Laboratory and Clinical Medicine*, February, 1942, page 594.

Notes on Books, Current Journals and New Appliances.

REGIONAL ANATOMY.

THE fifth edition of E. B. Jamieson's atlas of regional anatomy has been published;[1] two years have elapsed since the fourth appeared. In the preface to the fifth edition the author describes the fourth edition as running out with a rapidity that is almost embarrassing. This is not to be wondered at, because the atlas is so obviously useful that no student, graduate or undergraduate, once he has had access to it, will want to be without a copy. A few illustrations have been added to this edition. The work is in seven sections, dealing respectively with central nervous system, head and neck, abdomen, pelvis, thorax, upper limb and lower limb. Heavy art paper has been used and the printing has been admirably done—a matter of great importance in such a work. The author is to be congratulated on being able to continue production of the atlas in wartime.

[1] "Illustrations of Regional Anatomy", by E. B. Jamieson, M.D.; published in seven sections; Fifth Edition; 1944. Edinburgh: E. and S. Livingstone. 8" x 6¼". Price: 75s. net. Postage 10d.

The Medical Journal of Australia

SATURDAY, OCTOBER 28, 1944.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE MEETING OF THE FEDERAL COUNCIL.

The meeting of the Federal Council of the British Medical Association in Australia, reported in this issue, was held in the shadow of a conference at Canberra, staged by the Minister for Health in June, 1944, and in the aura of another, arranged to take place four days after the meeting started. From such accounts of these conferences as have been published, two things must be obvious, first, the peculiar ideas that ministers of the Crown seem to have about what a conference is, and secondly, the patience and longsuffering of the medical profession. That ministers have looked on "conferences" of this kind as nothing but an opportunity for the statement of intentions is abundantly clear from the account of the June episode given by Sir Charles Blackburn in his opening address to the convention of the New South Wales Branch held on September 8, 1944. (See The Medical Journal of Australia, September 30, 1944, page 368.) The representatives of the profession were led to believe that before the June meeting "everything was still in the melting pot" and that a general discussion was to be held "out of which a definite plan would take shape". However, this was not to be, and the Minister for Health, "after very cordially welcoming those taking part", stated the Government's intention "that every citizen shall have available the highest grade of medical service, without cost to himself or herself, other than such general contributions as may be made through general revenue channels". The Treasurer "followed with some more forthright and less cordial remarks". He said that a plan had been laid down; apparently the medical profession would not cooperate, but the Government intended to go on with its policy all the same. He then went on to say that from those whose medical courses were being financed by the Government, a pool would be formed, and that from this pool would emerge medical graduates pledged to give their service to the Commonwealth Government for a period of years. In other words: "We have asked you to a conference, but whether you like it or not, we intend to put our ideas into practice and we are training our own men to work for us." All members of the profession who have followed the discussions of the Federal Council, whatever their views on medical politics may be, will regret this stand-and-deliver attitude. The Federal Council, it will be remembered, has adopted at least "one acceptable substitute for any unacceptable scheme proposed by the Government". The Treasurer did not bother to go into this possibility before delivering his ultimatum. The representatives of the profession showed patience and longsuffering by not leaving the conference chamber after the Treasurer had spoken. For this they are to be commended. The questions at issue are of such tremendous moment that every effort must be made to avoid a wrong decision. Apparently the Federal Council thought that nothing was to be gained by abrupt action, and the invitation of the Minister for Health to appoint a committee of six to meet government representatives after the recent meeting was accepted. Readers will not fail to note that a great deal of time was spent at its last meeting by the Federal Council discussing in committee the instructions to the six representatives who were to meet the Government, and also that the resolutions embodied in the instructions have been adopted as the policy of the Federal Council in future discussions with the Government in connexion with a possible government medical service. When therefore members of the Branches ask, as they undoubtedly will ask, what the Federal Council has done at its last meeting, the question may best be answered in the terms of the fifth motion moved by Dr. H. C. Colville, stating that the Federal Council is willing to discuss any scheme put forward by the Government for the expenditure of public money on the provision of financial relief for individuals arising out of illness, provided the following three conditions are observed: (*a*) That the negotiations shall not proceed beyond the stage of discussion until one year after the war. (*b*) That the scheme retains the existing doctor-patient relationship. (*c*) That the scheme shall be free from departmental or any other method of control which would interfere with the freedom of the profession and the public. At the conference held after the Federal Council meeting, a statement was drawn up and presented to the Federal Council, but the statement has been withheld from this journal. Against this method of procedure we must enter a strong protest; it is a practice that recalls unpleasant happenings of a few years ago. On this occasion, however, the members of the Branches will have the statement presented to them by their Branch Councils. The outcome of the conference was in effect nothing more than a determination to keep the door open for future discussions. In this regard there may be significance in the fact that the General Secretary of the Federal Council (Dr. J. G. Hunter) and the Medical Secretary of the Victorian Branch (Dr. C. H. Dickson) have gone to New Zealand to study the fee-for-service system operating in the Dominion, that the Commonwealth Government has done everything in its power to make conditions easy for the two travellers, and that the Commonwealth Minister for Health also proposes to visit the Dominion, presumably with the same object in mind.

Among the other matters dealt with by the Federal Council was the *Pharmaceutical Benefits Act*. By this

time members of the Branches are familiar with the views of the Federal Council and especially with its refusal to look with favour on the act because of its interference with the freedom of the individual—the freedom of the practitioner working under the act to prescribe according to his patient's needs, and the freedom of the patient to receive proper treatment without his being excluded from the benefits of the act. The statements in the present report drafted for the public and for the profession should be studied by every doctor, and heed should be paid to the Federal Council's advice to members of the profession not to cooperate with the Government in the use of the proposed formulary on the prescribed forms. If the members of the profession act together in this matter, they will show a belief in the justness of their contention, and their views on other matters may later on be examined by government authorities engaged in medical planning with more understanding and less prejudice than they have heretofore shown.

The Federal Council has told the Central Medical Coordination Committee that the medical profession wishes to take a major part in the rehabilitation of service medical officers. From every point of view this would be the most desirable arrangement, particularly from that of the service medical officer. The medical officer in the services is likely to receive more useful assistance from a sympathetic body of practitioners than from a non-medical body or a government department. This question was discussed recently in these pages under the title "Only the Best is Good Enough"—a slogan that might well be borne in mind in all discussions on the future of service personnel. That difficulties will probably arise because the set-up of medical practice in the future is likely to undergo some change, does not alter the obligation of men already in practice to be prepared to open their ranks to newcomers from the services. Practitioners must learn to look at the repatriation of service medical officers not as something that happens to returned soldiers, but as something that they, the practitioners themselves, have to do for their colleagues. If this point of view is widely adopted, Branch Councils will have no great difficulty in securing the necessary data.

Finally, mention of repatriation must be followed by reference to the Federal Medical War Relief Fund shortly to be established. This fund will be available to all medical practitioners who have been incapacitated or who may have fallen on evil days as a result of service, and to the dependants of those medical officers who have died as a result of enemy action or of sickness contracted while serving with the armed forces. There is no doubt that the response to the forthcoming appeal for donations will be prompt and generous.

Current Comment.

PUBLIC HEALTH MATTERS IN WESTERN AUSTRALIA.

In pre-war days a report of the Public Health Department of Western Australia was issued every two years. During the war publication of the reports was suspended. A report covering the work of the department for the years 1939-1943 inclusive has now been printed. It comes from Dr. Everitt Atkinson on the eve of his retirement after having occupied the position of Commissioner of Public Health for thirty years. Unfortunately the report is compiled on exactly the same lines as those that have gone before it. Had Dr. Atkinson given a review of the measures adopted during the last thirty years to improve the public health, much interest would have been aroused. Such a review would have lent more weight to any recommendations he might have made for the future. However, some of the more important features of the report as it stands should be mentioned.

To begin with, the population of Western Australia is not yet half a million. In 1939 the number was 465,042; in 1942 (the latest year for which figures are available) the number was 470,100. The birth rate increased from 19·43 per thousand of mean population in 1932 to 22·07 in 1943. The death rate increased from 9·32 per thousand in 1939 to 9·66 in 1943. The natural increase rate per thousand of mean population was 10·11 in 1939 and 12·41 in 1943. It is interesting to note that the infantile death rate (stated by Dr. Atkinson to be second only to that of New Zealand) was as low as 32·63 per thousand births in 1943. When we look at the map of Australia and consider these figures in relation to the enormous area covered by the State (975,920 square miles—it is by far the largest of the States), and when we think of Australia and her needs in the post-war period, we must conclude that problems of population are among those demanding the most urgent attention. This is much more than a medical problem, for important though they are, public health considerations—low death rate and high birth rate—will not alone provide a solution.

Some interesting figures are given in connexion with infectious diseases. In 1943 there occurred 755 cases of diphtheria, 659 in the metropolitan area and 69 in country districts. There were 38 deaths, a case mortality of 5·03%. The percentage of cases occurring in the country is less than it was in 1939; in 1943 the percentage was 12·7, in 1939 it was 29·7 (181 cases among 610). The case mortality has risen from 4·4% in 1939 to 5·03% in 1943. During 1942 "a more virulent type of the disease appeared". The suggestion is made that the alteration in incidence, as between metropolitan and country areas, may be due to the exodus of a considerable number of children from country to metropolis "where the chances of infection are greater than in the more sparsely populated country areas where, moreover, natural immunity has less opportunity to develop". It is estimated that not less than 65,000 children have been immunized in the State, and we read that "the actual cases of diphtheria among those so dealt with, has been small, and then of mild type only". Readers of this journal were reminded some little time ago that the effective inoculation rate in diphtheria is held to be 80% of susceptible individuals. No information is given in the report regarding the ages of the children immunized, but if we presume that they range from two to twelve years covering the most susceptible age period, we shall also conclude that the 65,000 children do not represent 80% of the children in this age period. This means that though a substantial and useful start has been made in this work in Western Australia, more remains to be done.

Morbilli and rubella were particularly prevalent during 1940 and the former was made notifiable for a short period. In 1940 no less than 1,013 cases were notified, but many mild infections were not notified. In view of the recent reports on rubella and subsequent appearance of lenticular changes and other developmental abnormalities, the incidence of the disease should if possible be determined. Public health departments throughout the Commonwealth may be able to help in this direction. In 1938 the number of cases of acute anterior poliomyelitis in the State was 48; since then the number of infections reported every year has varied between three and sixteen. Cerebro-spinal meningitis made its appearance soon after the outbreak of war and sporadic cases began to occur in August, 1940. Among civilians an epidemic occurred with its peak in 1941—in this year 411 infections were notified and there were 70 deaths. Previously the death rate had been as high as 60%; it has fallen since the introduction of sulphonamide drugs. In various groups of cases the

mortality varied according to the rapidity with which patients were brought under the influence of the drugs. Endemic typhus or Brill's disease has become more prevalent lately, and in 1943 no less than 123 infections were notified. It is thought that rats conveying the infection may have become more prevalent because of lack of manpower to destroy them. The work on tuberculosis will be considered on another occasion.

Few people realize that leprosy presents a real problem in Western Australia. During the last five years the number of infections notified has been as follows: 1939, 62; 1940, 52; 1941, 43; 1942, 26; 1943, 69. These infections total 252. The patients, we are told, are segregated at the Derby Leprosarium, where they are cared for by the local medical officer and nursing sisters from the Broome convent. Only four of the patients are white persons, and these appear to be cared for at the Wooroloo Sanatorium. Assistance is given to the Western Australian department in the control of the disease by the Commonwealth Government. Of the patients who were found to be infected during the last five years, 32 are not accounted for in the statement that those "housed in the institution" (they are not even stated to be under treatment) "at the time of writing", numbered 220. No doubt also some patients were being treated at the beginning of 1939. It is claimed that in regard to leprosy, Western Australia "must deal with a problem of great national importance in which the more populous States of the Commonwealth, with the exception of Queensland, take no part". In spite of this claim, no information is given of the methods of treatment used or of the results obtained. We are not told how many patients have died and how many have been discharged cured. No doubt useful work is being done, but this report should give some indication of its nature and extent.

Included in the report is a special section written by Dr. E. M. Stang, Senior Medical Officer of Schools for Western Australia. This is such an important document that it should really be considered separately. If Dr. Stang does nothing else, she shows that the fringe of the work only can at present be touched. We are tempted, as no doubt everyone else will be, to say that during wartime such an activity as medical inspection of schools must give place to more urgently needed work in the curative sphere. In her second paragraph, however, Dr. Stang makes one ask whether this would be wholly justified. During the depression the school medical and nursing staff was sadly depleted and the losses in staff that occurred at that time have never been made good. This surely is something that cannot be defended in such a richly endowed country as Australia. When we talk of the rehabilitation of service medical officers we must recognize that in services such as that controlled by Dr. Stang room will be found for quite a number of medical men or women. At present all that can be done is to sympathize with Dr. Stang and with the medical officer who does the work in country schools in their efforts to meet a hopeless situation. The country medical officer is able to visit each individual school only about once in three or four years. The medical officer in the metropolitan area, Dr. Stang herself presumably, can devote only part of her time to school work, as the rest has to be devoted to infant health work. The opportunities of the post-war period must not be allowed to slip.

THE EFFECT OF SMOKING TOBACCO.

Many experiments have been carried out to ascertain the effect of tobacco and its active ingredient nicotine on the circulation of man. Work began on this subject thirty-five years ago and has continued at intervals ever since. It is not surprising that a reawakening of interest has taken place recently, when we consider what vast quantities of tobacco are smoked today. Most of the investigators have shown that constriction of the peripheral blood vessels is a constant effect of tobacco smoking, accompanied by an elevation of the blood pressure and pulse rate. These effects can be closely paralleled by the intravenous injection of nicotine, and it has been shown that the smoke from an ashless cigarette paper is without effect. Thus it seems reasonable to suppose that it is the nicotine in the tobacco that causes the vaso-constriction. Some workers have pointed out that deep breathing, cold or psychic stimulation may cause a diminution in the peripheral blood flow, but these factors can be eliminated by careful technique in the planning and execution of the experiments. Similar changes have been found in subjects smoking cigarettes free from nicotine, however, and it has been suggested that pharyngeal irritation from smoke may cause sympathetic stimulation.

Grace M. Roth, John B. McDonald and Charles Sheard have summarized these findings in a recent paper.[1] They concluded some time ago that a more extended series of observations was desirable. They therefore carried out 66 tests on six subjects, all of whom were smokers and were physicians or laboratory workers and well accustomed to experimental conditions. Ordinary standard cigarettes, as sold in the open market, were used, and as a control, cigarettes made from corn silk. Studies were also made with standard cigarette papers and special ashless papers, both tobacco and corn silk being used in order to control the possible factor of irritation arising from smoke itself. A filter holder was used for some experiments, and puffing at an unlighted cigarette was tried as an additional control. All the work was carried out in a room with constant temperature and humidity. Cutaneous temperatures were observed with the subjects reclining, sitting and walking slowly, wearing pyjamas and also fully dressed. Basal blood pressure and pulse rate were ascertained in each case, and all possible noise and other extraneous stimuli were excluded. The subjects smoked after their usual fashion, and simultaneous pulse, blood pressure and cutaneous temperature readings were taken every minute during the smoking periods, which lasted some twelve to sixteen minutes, and further observations were made half to one hour after the smoking. Electrocardiographic tracings were taken before and after the smoking of two standard cigarettes and the controls. Cold pressor tests were carried out on each subject, that is, the pulse rate and blood pressure variations were noted following immersion of one hand in water at 4° C. for one minute. Parallel observations were made after the intravenous injection of isotonic saline solution into which two milligrammes of nicotine were run at a moment unknown to the subject. It will be seen that these experiments were very thoroughly carried out; in fact, it may be believed that the subjects well earned the solace of a smoke. The results are set forth in graphic form and a thorough discussion of these is made by the authors. Their final conclusions are as follows. The smoking of two standard cigarettes constantly reduced the surface temperature, whether the subject was at rest or engaged in slow walking, whereas cigarettes not containing nicotine produced no such effect. Additional interesting effects were found to be an increase of the metabolic rate, raising of the heart rate, and lowering of the amplitude of the *T* wave in the electrocardiogram. Once more, control cigarettes gave no result. The effect of nicotine when injected intravenously was to produce changes identical in kind with those found after smoking, though they were more intense, which is not surprising when one considers the sudden and positive effect of introducing a drug directly into the blood.

There was an occasional parallelism between the effects of reaction to cold and to tobacco, but as this was not constant it was thought that this factor was not significant. Roth, McDonald and Sheard therefore produce additional convincing evidence that smoking does cause vaso-constriction in the peripheral circulation and that this effect is due to nicotine. It would appear that there is some scientific justification for advising reduction in or abstention from smoking by patients suffering from diseases in which the vascular factor plays an important part.

[1] *The Journal of the American Medical Association*, July 15, 1944.

Abstracts from Medical Literature.

PHYSIOLOGY.

The Effect of Caffeine upon Gastric Secretion in the Dog, Cat and Man.

J. A. Roth and A. C. Ivy (*The American Journal of Physiology*, June, 1944) state that caffeine has been shown consistently to have no effect upon gastric secretion in Pavlov and Heidenhain pouch dogs. In regard to the cat no references could be found in the literature, whereas in regard to man considerable disagreement exists. The authors report their results on the effect of caffeine on gastric secretion in man, cat and dog. They have confirmed the observation of the earlier investigators that caffeine does not stimulate gastric secretion in the dog. Caffeine, administered by the intravenous route or by lavage of the stomach, provokes a copious flow of acid gastric juice in the cat. The significance of this species difference is pointed out. Caffeine, administered intramuscularly or by the oral route, stimulates gastric secretion in man. The dog has been the most frequent choice for studies on the mechanisms of gastric secretion, on the production of gastro-duodenal ulcers, and on the effectiveness of various therapeutic procedures on experimentally induced peptic ulcer. Therefore, the observation that caffeine does not stimulate gastric secretion in the dog, but does do so in man and the cat, is very significant and has far-reaching implications. That such a species difference does exist must constantly be borne in mind when observations made on the dog are applied to various physiological phenomena in man.

A Study of Gelatine and Saline Solution as Plasma Substitutes.

W. W. Swingle, W. Kleinberg and H. W. Hays (*The American Journal of Physiology*, May, 1944) describe the results obtained by the use of injections of gelatine and saline solution as plasma substitutes in dogs in which a hind limb has been crushed. The application of a Duncan-Blalock press to one hind leg of the deeply anæsthetized dog for seven hours at 750 pounds' pressure induced fatal shock in 25 of 26 untreated control animals. The average survival period following release of the press was eleven hours. Anæsthesia was continued for eighteen to twenty-four hours in all of the experiments or until the animal died. The shock is characterized by intense hæmoconcentration, progressive fall in arterial pressure and loss of plasma. There is an average decline in plasma volume of 48%. The greatly swollen leg indicated that most, if not all, of the decline in plasma volume could be accounted for by loss of plasma into the injured area. A single massive intravenous infusion of gelatine representing 40 cubic centimetres per kilogram, given immediately after removal of the leg press, failed to prevent fatal shock in ten of eleven dogs. The gelatine was apparently not retained in the circulation, but rapidly passed through the injured capillaries of the limb. Six intermittent gelatine infusions of 6·6 cubic centimetres per kilogram each, administered over an eight-hour interval from the time of removal of the leg press, prevented shock in 19 of 26 animals. Intermittent infusions of 0·9% saline solution, administered in equal dosage and over the same time interval as the gelatine, proved to be less effective. Eight of 23 dogs survived and fifteen died. Small intermittent infusions of pooled, heparinized dog plasma administered in the same dosage and over the same time interval proved no more effective in preventing shock than similar infusions of gelatine. Intermittent infusions of plasma or plasma substitutes, when given in small amounts over a period of hours, are more effective in preventing shock than is a single massive infusion.

In-Vivo Hæmolysis Produced by Soap Injection.

L. W. Freeman, A. Loewy and V. Johnson (*The American Journal of Physiology*, January, 1944) report the results of injections of fatty acid or soaps on the rate of red cell destruction in dogs. The dogs were anæsthetized with barbital and the rate of red blood cell destruction was determined by collection of bile and by quantitative analysis of the bile pigment excretion. The intravenous injection of as little as 5·0 milligrammes of soap or fatty acid per kilogram produced a definite increase in red blood cell destruction. Red cell destruction was greater when larger quantities of fatty acid or soap were injected. Bile pigment excretion started to increase in the course of the hour during which the fatty acid or soap was injected. In some cases the increased secretion persisted for some hours after the injection was stopped. Calculations from these and other data indicate that absorbed free fatty acids and soaps from the fat of a normal diet are responsible for the lytic destruction of a significant proportion of the daily red blood cell destruction in a normal human being. Estimated conservatively, red cell destruction from this cause is from 8% to 35% of the total daily destruction. Further support is lent to the concept that absorption of the products of fat digestion into the lymphatics is an adaptive mechanism, preventing excessive destruction of red blood cells.

Gastric Emptying Time of Man at High and Normal Environmental Temperatures.

A. Henschel, H. S. Taylor and A. Keys (*The American Journal of Physiology*, April, 1944) state that decreased appetite is frequently observed in hot weather, and there is a widespread belief that high environmental temperatures have a depressing effect on gastric activity. Some experimental evidence designed to explain decreased appetite during hot weather has been presented, the decrease in appetite being correlated with an increased gastric emptying time. The authors determined the gastric emptying times of seventeen normal young men in rest at environmental temperatures of 77° F. and 120° F. In all but one of the subjects the gastric emptying time was faster at the high temperatures. Twelve of the subjects had an average decrease of 30% in the gastric emptying time when the temperature was 120° F. Observations on about 100 normal men doing hard work at 120° F. failed to indicate any lack of appetite or any signs of decreased gastric activity, except in actual heat exhaustion.

Cold Sweating in Motion Sickness.

A. Hemingway (*The American Journal of Physiology*, April, 1944) states that cold sweating may be defined as sweating which occurs without an adequate thermal stimulus. Its occurrence as one of the symptoms of motion sickness has been given scant attention even in the most complete descriptions of sea-sickness. During investigations on experimental motion sickness with men as subjects, cold sweating was the most reliable and constant indication of the onset of motion sickness. The occurrence of sweating was detected with a galvanometer. It has been found that the sweating occurs as a result of motion and when the mouth temperature is falling. There appears to be no useful physiological purpose in cold sweating, and the mechanism is probably part of a primitive defence reaction.

The Effect of Aluminium Hydroxide Gel on Gastric Secretion.

W. L. Adams and B. B. Clarke (*The American Journal of Physiology*, April, 1944) have already reported the effect of sodium bicarbonate on the "rebound" or "secondary" acid secretion of the stomach, and now report results obtained by the use of aluminium hydroxide as an antacid. The effect on pouch secretion of five consecutive days of the feeding of moderate doses of aluminium hydroxide gel three times a day after a test meal was studied with the Cope pouch dog. No depression of secretory activity occurred either during or after the administration of the antacid. The administration of moderate doses of aluminium hydroxide gel was accompanied by occasional increases in volume, total chloride, total base, and free acid of the pouch secretion, but in the majority of experiments these increases were too small to be significant.

Environmental Temperature and Vitamin K Deficiency.

C. A. Mills, E. Cottingham and M. Mills (*The American Journal of Physiology*, May, 1944) state that experimental production of fatal hæmorrhagic vitamin *K* deficiency in otherwise normal mammals has not previously been reported, although severe bleeding tendencies have followed ligation of the common bile duct or the production of a biliary fistula. When a large series of rats were placed on a diet devoid of vitamin *K* and were at the same time placed in tropical moist heat, a hæmorrhagic tendency was evinced. The authors state that severe and highly fatal vitamin *K* deficiency can be produced in rats adapted to tropical heat by the use of synthetic diets devoid of vitamin *K*, but containing 0·5% sulphaguanidine. This deficiency is most severe and fatal early in the third week of such feeding and disappears almost entirely by the fifth week. Animals adapted to tropical heat seem more prone to severe manifestations of vitamin *K* deficiency than do those kept in temperate coolness, and the vitamin *K* requirement per gramme

of food is twice as high for rats in the heat as for those in the cold. A preliminary survey of hospital statistics on bleeding in the newborn shows this type of human vitamin *K* deficiency to be four times more prevalent among infants born in the Gulf States than among the northern-born. Fatal hæmorrhages in male rats on diets devoid of vitamin *K* are especially prone to occur in the genital system and around the superior mesenteric vein.

BIOCHEMISTRY.

Methionine.

J. P. GOODELL *et alii* (*Journal of Experimental Medicine*, June, 1944) have investigated the action of methionine in giving protection against "Mapharsen" liver injury in dogs whose protein stores have been depleted. Depletion of body protein stores by means of low protein diet or plasmaphoresis causes greater susceptibility to liver injury by the arsenical compound "Mapharsen". Normal dogs can tolerate "Mapharsen" in doses of 0·006 to 0·008 gramme per kilogram, whereas in protein depleted dogs doses of 0·002 to 0·0025 gramme per kilogram cause liver injury with jaundice. Methionine (2·0 to 4·0 gramme) given by mouth twenty to twenty-four hours prior to administration of "Mapharsen" is protective and the dogs will tolerate 0·0045 gramme per kilogram without the development of icterus. Methionine (1·0 gramme) intravenously just prior to "Mapharsen" injection is not as consistent in effecting protection, but the smaller dose may be responsible.

Plasma Proteins.

S. MADDEN *et alii* (*Journal of Experimental Medicine*, June, 1944) have studied amino acid mixtures effective parenterally for long-continued plasma protein production; they have used various casein digests. When plasma proteins are depleted by bleeding with return of red cells suspended in saline solution (plasmophoresis) it is possible to bring dogs to a steady state of hypoproteinemia and a constant level of plasma protein production if the diet nitrogen intake is controlled and restricted. Such dogs are outwardly normal, but have a lowered resistance to infection and to certain intoxications. The ten amino acids of Rose essential to growth *plus* glycine will maintain nitrogen balance and produce as much new plasma protein as will good diet proteins. This good utilization is demonstrated over periods of several months when the amino acids are given either orally or parenterally. There is no evidence of toxicity in general nor of unnatural forms of these synthetic amino acids in particular. Given parenterally, appropriate mixtures of these amino acids are well tolerated, even upon rapid injection. The minimal daily requirements for a ten kilogram dog may be given intravenously in ten minutes without reaction. Subcutaneously a 10% solution may be given rapidly without reaction. The following mixture approximates a minimum for a ten kilogram dog. It contains in grammes *dl*-threonine 0·7, *dl*-valine 1·5, *l*-(−) leucine 1·5, *dl*-isoleucine 1·4, *dl*-lysine hydrochloride 1·5, *l*(−) tryptophane 0·4, *dl*-phenylamine 1·0, *dl*-methionine 0·6, *l*(+)-histidine hydrochloride 0·5, *l*(+)-arginine hydrochloride 0·5, and glycine 1·0. The presence of glycine improves tolerance to rapid intravenous injection, but excess glycine does not improve utilization of the mixture. Over a long period this mixture appears suboptimal in quantity. In double quantities it is more than ample. Of two casein digests tested, the one prepared by enzymatic hydrolysis provided good nitrogen retention and fairly good plasma protein production, but was much less tolerable upon intravenous injection than certain mixtures of pure amino acids. The other one prepared by acid hydrolysis and tryptophane fortification afforded base nitrogen equilibrium and produced virtually no plasma protein. Skin lesions observed after ten to twenty weeks of synthetic diet probably reflect a deficiency of some member or members of the vitamin B_2 group. A persistent slight weight loss in the face of a strongly positive nitrogen balance may accompany this deficiency.

Carcinogens.

P. ROUS AND W. FRIEDEWALD (*Journal of Experimental Medicine*, May, 1944) have investigated the effect of chemical carcinogens on virus-induced rabbit papillomata. The application of methyl cholanthrene and tar to virus-induced papillomata of the domestic rabbit caused them to become carcinomatous with great rapidity, and the malignant changes were frequently multiple. In bringing on the cancers, the chemical agents acted in their specific capacity as carcinogens, not as ordinary stimulants of cell proliferation. The cancers were derived from the virus infected cells and were of the same types as arise from these elements spontaneously after a much longer time. The evidence would seem to indicate that the chemical carcinogens acted by way of the virus.

Histidine.

A. A. ALBANESE *et alii* (*The Bulletin of the Johns Hopkins Hospital*, April, 1944) have made observations on the effects of a histidine-deficient diet on man. The subjects remained in nitrogen equilibrium, but lost weight. The histidine deficient-state was characterized by the appearance of an abnormal metabolite in urine, a substance giving a green colour reaction with the Sharlit indican test. Reasons are given for questioning the conclusion that histidine is a non-essential dietary constituent for man.

Sex Hormones.

K. BUCKWALD AND L. HUDSON (*Endocrinology*, August, 1944) have studied the effects of sex hormones on acid and alkali phosphatase activity, calcium and phosphorus. Daily subcutaneous injections of 0·1 milligramme of diethylstilbœstrol and 0·2 milligramme of testosterone propionate were given mature male and female rats, respectively, for 28 day periods. There was no change in the serum calcium content nor in the output of calcium and phosphorus in the fæces. The serum phosphorus content was not influenced by the testosterone propionate, but diethylstilbœstrol produced an apparent decrease. Diethylstilbœstrol also produced a decrease in the acid phosphatase activity of the blood serum and the alkaline phosphatase activity of the femora, but had no influence on the alkaline phosphatase activity of the blood serum. The decrease in the alkaline phosphatase activity of the femora may be related to the difficulty observed in the healing of bone metastases in carcinoma of the prostate. Testosterone propionate produced an increase in alkaline phosphatase activity of the serum without influencing the acid phosphatase activity of the serum or the alkaline phosphatase activity of the femora.

Soya Flour.

R. S. HARRIS *et alii* (*Archives of Biochemistry*, May, 1944) have investigated the nutritional value of bread containing soya flour and milk solids. The superior nutritive value of bread containing soya flour has been demonstrated. Soya flour supplements the proteins of milk in the bread formula. A bread containing 3% skim milk solids and 2·3% full fat soya flour was superior to a bread containing 6% milk solids not fat.

Choline Substitutes.

C. A. MILLS AND E. COTTINGHAM (*Archives of Biochemistry*, May, 1944) have investigated caffeine and methionine as choline substitutes in tropical heat. Methionine seems able to replace choline in preventing acute hæmorrhagic nephritis in weanling rats and in supporting subsequent normal growth in either hot or cold environments. Caffeine gives somewhat poorer protection against hæmorrhagic nephritis and much poorer support to subsequent growth. It appears more toxic in the cold than in the heat, and this toxicity may be responsible for the poor growth at high intake levels.

Serum Phosphatase.

B. S. GOULD (*Archives of Biochemistry*, May, 1944) has studied the nature of the increased serum phosphatase in rats after fat feeding. Prolonged feeding of fat to rats results in an increase in the serum phosphatase content to extremely high levels. The increase in serum phosphatase content after fat feeding and the decrease after fasting are due to a quantitative alteration in the enzyme rather than to the action of an inhibiting or activating agent. The increased serum phosphatase content does not appear to be of bone or kidney origin, but may be of intestinal origin.

Manganese Deficiency.

S. E. SMITH *et alii* (*Archives of Biochemistry*, May, 1944) have studied manganese deficiency in the rabbit. Manganese deficiency seriously interferes with normal bone development and is grossly most evident in severely deformed front legs. There is a decrease in breaking strength, weight, density, length and ash content of the humeri of deficient animals. A microscopic study of the humeri revealed extensive deviations from normal which are interpreted as suppressed osteogenesis. There was a significent decrease in growth and a decreased content of manganese in the liver of manganese-deficient rabbits as compared to controls. Testicular degeneration was found in the deficient males.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A meeting of the Federal Council of the British Medical Association in Australia was held at the Medical Society Hall, Albert Street, East Melbourne, on September 25, 26, 27 and 28, 1944, Sir Henry Newland, the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. George Bell, O.B.E.; Dr. W. F. Simmons.
Queensland: Dr. T. A. Price; Dr. A. E. Lee.
South Australia: Sir Henry Newland, C.B.E., D.S.O.; Dr. R. J. Verco.
Tasmania: Dr. C. Craig; Dr. J. S. Reid.
Victoria: Dr. F. L. Davies; Dr. H. C. Colville.
Western Australia: Dr. N. M. Cuthbert; Dr. F. W. Carter.

Minutes.

The minutes of the previous meeting of the Federal Council of May 30 and 31 and June 1 and of June 28, 29 and 30, 1944, which had been circulated amongst members, were taken as read and signed as correct.

Appointment of a Committee to Confer with the Government.

The President said that the Federal Council had power to appoint committees to act for any special purpose. He referred to the decision to appoint a committee to meet government representatives and said that members of the committee had been nominated by the Branches. He stated that if it was thought that Dr. Verco would be a more suitable representative for South Australia, he was quite willing to stand down. The General Secretary pointed out that the President had been appointed by the South Australian Branch as its representative. It was then decided on the motion of Dr. George Bell, seconded by Dr. F. L. Davies, that the following committee should be appointed: The President, Dr. A. E. Lee, Dr. H. R. R. Grieve, Dr. C. Byrne, Dr. F. W. Carter, Dr. C. Craig.

In regard to the giving of instructions to the committee, it was decided that the Federal Council should go into committee when discussing the Commonwealth Government health proposals and that Dr. H. R. R. Grieve and Dr. C. Byrne should be invited to take an active part in the discussions.

Annual Report of the Federal Council.

The annual report of the Federal Council for the year ended June 30, 1944, was adopted.

Finance.

Dr. George Bell presented the financial statement and balance sheet as at June 30, 1944. The statement, which included the Federal Council account and the Australasian Medical Congress (British Medical Association) Fund Account, was received and adopted.

At the meeting of the Federal Council in May, 1944, it had been resolved that a further call of four shillings per member should be made on the Branches to meet the general expenses in 1944. It was noted that since then another call of three shillings per member had become necessary. The Victorian Branch wanted to know whether this further call had been authorized. It was pointed out by Dr. George Bell that the call had been necessary because of the extra meetings of the Council and the recent conference at Canberra. Dr. H. C. Colville expressed the opinion of the Victorian Branch that the expenses in connexion with the conference at Canberra should be paid by the Government. With this Dr. C. Craig agreed. It was stated that the Director-General of Health in a letter agreeing with the holding of the forthcoming conference in Melbourne, had suggested that the arrangement was suitable because it would involve the Federal Council in no extra expense, and it was pointed out that this was far from correct.

It was resolved that a further call of three shillings per member should be made on the Branches to meet the expenses of the current year.

Dr. W. F. Simmons asked that provision should be made for the future. It might be quite impossible to obtain at short notice the approval of the Council to the calling up of a sum that was required to meet unavoidable expenditure in connexion with meetings called because of some emergency. The Council then resolved that the General Secretary should obtain legal advice on the amendment of by-laws so as to provide that the Honorary Treasurer, acting on behalf of the Federal Council, might be empowered to make additional calls on the Branches within the maximum limit provided by the present by-law dealing with expenses.

The Federal National Health Insurance Emergency Account.

At the May meeting of the Federal Council consideration was given to the possibility of using for organization purposes the money in the national health insurance emergency account. In accordance with a legal opinion the Branches had been asked whether they would consent to this use of the money. All had agreed except the New South Wales Branch, which had referred the matter to the local medical associations. The General Secretary reported that the local associations had unanimously agreed to the proposal. The amount in the fund stands at £528. The decision was noted.

Allowances to Federal Councillors and Pay-Roll Taxation.

Discussing the *Pay-Roll Tax Assessment Act*, 1941-1942, the General Secretary reported that he had obtained a ruling from the Taxation Department on the living and practice allowances paid to Federal Councillors. These were exempt from taxation.

Medical Officers' Relief Fund (Federal).

Dr. George Bell presented the report of the trustees of the Medical Officers' Relief Fund (Federal) for the year ended June 30, 1944. It was noted that the total assets of the fund at June 30 were £9,374. The report was received.

Decorations Received by Medical Officers of the Armed Forces.

The General Secretary reported that on behalf of the President and members of the Federal Council, he had offered congratulations to Wing Commander S. F. Reid, who had been honoured by His Majesty the King.

Request for Copies of Federal Council Minutes.

A letter was received from the Victorian Branch asking that a copy of the minutes of the Federal Council meeting should be forwarded to the Branch. In reply to a question, the General Secretary said that he did not approve of the suggestion, mainly because the minutes contained many of the remarks of members of the Council in discussion. He would have no objection to sending copies of the resolutions. Dr. H. C. Colville said that he thought this would do. It was resolved that a copy of all the resolutions passed at Federal Council meetings should be forwarded to the Branches.

Visit of Sir Howard Florey to Australia.

Letters were received which had passed between the Director-General of Health and the President regarding the itinerary of Sir Howard Florey, Professor of Pathology in the University of Oxford, who was to address the Branches of the British Medical Association. The correspondence was noted.

The Closing of Butchers' Shops on Saturday Mornings.

The Queensland Branch forwarded a copy of a letter which it had addressed to the Registrar of the Commonwealth Court of Conciliation and Arbitration protesting against the closing of butchers' shops in Queensland on Saturday mornings. The reasons for the protest were the following: (*a*) Meat would not keep in the Queensland climate from Friday to Monday. (*b*) Long week-ends would aggravate the problem. (*c*) The preserving of meat by corning and recooking affected the nutritive value of the meat. (*d*) Most people could not afford to buy refrigerators at any time, and at present they could not be obtained by those who could afford to buy them. (*e*) Ice chests were unobtainable in sufficient numbers. (*f*) Ice delivery was irregular and uncertain and likely to become worse on account of shortage of motor-car tires, lack of manpower and the impossibility of keeping machinery in order. The Queensland Branch asked that the Federal Council would enter a protest or endorse the protest of the Queensland Branch. The General Secretary said that he had sent a copy of the Queensland Branch letter to the other Branches

and had also made a statement to the Press. During discussion it was clear that the Federal Council agreed with the views expressed in the Queensland Branch letter, but it was pointed out that climatic conditions varied greatly in the different States. Several members expressed the view that the question was one for State and not for Federal action. The correspondence was received.

Appreciation of the Work of the Federal Council.

The General Secretary read a leter from the Southern District Medical Association (New South Wales) expressing appreciation of the work of the Federal Council. The letter was noted with satisfaction and formally received.

Penicillin.

A letter was received from the Victorian Branch regarding supplies of penicillin. The Branch wrote at the instigation of one of its members, who stated that it was unreasonable that the doctor should be held personally responsible for the cost of penicillin used in the treatment of patients. The Victorian Branch asked the Federal Council to take up the matter with the authorities. It was suggested that the Government should take the risk of non-payment by the patient. The President said that this was an example of what might be expected in a medical service controlled by the Government. Dr. C. Craig pointed out that the use of penicillin was still in the experimental stage. Dr. H. C. Colville said that the position of the Government in the whole matter should be defined. If the function of the Government was to experiment in the matter of penicillin, then its procedure respecting payment was hard to understand. If the function was to supply the drug, then red tape methods were unnecessary. The public was entitled to the drug and should be able to obtain it. At the present time reports were more important apparently than the patient's welfare. There should be no delay in supply of the drug. Dr. A. E. Lee was in agreement with Dr. Colville. The Government not only was manufacturing the drug, but it had a monopoly. Importation was being prevented, though supplies were available from outside the Commonwealth. Dr. C. Craig said that medical men knew what happened when sulphonamides were introduced—the drugs were used in all kinds of conditions and without proper indications. On this account control of penicillin should be advocated. Medical practitioners needed to use more science in their drug therapy. After further discussion it was resolved on the motion of Dr. George Bell, seconded by Dr. H. C. Colville, that the Commonwealth Department of Health should be approached and that it should be pointed out that it was inequitable for medical practitioners to be held responsible for the cost of penicillin. It was also resolved that the Federal Council should ask the Federal Government to take steps to remove the existing obstacles to the supply of penicillin to the public, other than those necessary to prevent its use in unsuitable cases.

The Ophthalmological Society of Australia (British Medical Association).

It was noted that members of the Federal Council had received invitations to attend the meeting of the Ophthalmological Society of Australia (British Medical Association) which was to be held in Melbourne on October 12, 1944.

Young Graduates and Membership of the British Medical Association.

The General Secretary read a letter from the Western Australian Branch in regard to young graduates in medicine and membership of the British Medical Association. Dr. N. M. Cuthbert put the view that a reduced subscription might be accepted from the Branches in respect of young members and that the journals should be supplied to them at a reduced rate. It was most important to obtain young graduates as members of the Association. Dr. F. W. Carter referred to the overhead costs of the smaller Branches and said that their difficulties should be kept in mind. Dr. T. A. Price thought that smaller subscriptions might be accepted from young graduates; with this Dr. Craig agreed. Dr. Cuthbert thought that THE MEDICAL JOURNAL OF AUSTRALIA might be supplied to young graduates for a reduced amount. Dr. F. L. Davies did not think it fair to ask the journal authorities to do more than they were doing at present. Dr. N. M. Cuthbert moved that the Australasian Medical Publishing Company, Limited, should be asked to consider the cost of the journal to first and second year graduates. Dr. F. W. Carter seconded the motion. After further discussion in which mention was made of propaganda among medical students regarding the British Medical Association, the motion was put to the meeting and lost.

Housing Standards.

A further report by the Technical Bodies Advisory Committee on Housing Standards was received. The New South Wales Branch wrote regarding the continuation of Professor Harvey Sutton's appointment as a member of the Advisory Committee. Professor Harvey Sutton was reappointed as the Federal Council's representative.

The Australasian Medical Publishing Company, Limited.

The General Secretary reported that he had taken up with the Australasian Medical Publishing Company, Limited, the publication of a list of members of the Branches of the British Medical Association in Australia, and that a list of members on January 1, 1945, would be published shortly after the new year.

The balance sheet of the Australasian Medical Publishing Company, Limited, as at June 30, 1944, was received.

The Selection of Students for Medical Courses at Australian Universities.

At its previous meetings the Federal Council had given consideration to the selection of students for medical courses at Australian universities. Particular reference was made at the May meeting to an Australian officer who had completed one year of his medical course at the time of enlistment, and who wished to secure admission to an Australian university to finish his course. The General Secretary reported that he had taken up the matter with the Minister for the Army. The Minister had first of all replied that the matter was receiving attention and had then written stating that the officer in question was being given one month's leave so that he might resume his studies at the end of that period.

At the May meeting of the Federal Council it was also resolved that the Minister for the Army should be approached regarding the release of students for the completion of their course and to the Universities Commission regarding the admission of ex-service men to university quotas for admission to medical schools.

The General Secretary reported that he had received a letter from the Minister for the Army setting out the arrangements already in existence. The Minister wrote as follows:

> The army has agreed to discharge soldiers who desire to commence or continue courses in the Faculty of Medicine and certain other faculties, subject to the following conditions.
>
> (*a*) Discharge will only be approved under the recommendation of the Director-General of Manpower or his deputies, which recommendation must state that the Universities Commission agrees in the recommendation.
>
> (*b*) Where the application is for the discharge of a soldier to resume a course interrupted by enlistment, not less than one year must have elapsed since date of enlistment.
>
> (*c*) Where the application is for the discharge of a soldier to commence a course, not less than two years must have elapsed since date of enlistment.
>
> (*d*) No graduate of any one faculty will be discharged for the purpose of commencing a course in another faculty.
>
> (*e*) No officer, warrant officer or N.C.O. above the rank of corporal, who is medically fit class A1, will be discharged.
>
> (*f*) Applications for the discharge of personnel serving at operational stations outside the Australian mainland will not be approved.
>
> The Universities Commission may recommend special cases which would otherwise come within the provisions of (*b*) to (*f*) above, which will be considered on their merits. It is necessary for such applications to be considered by the Universities Commission in relation to the quotas of students allotted to the various Faculties and to ensure that students with the best qualifications only are admitted.

The General Secretary said that the Queensland Branch was not satisfied with the conditions. The Victorian Branch thought that a further request should be made. The Western Australian Branch agreed that the concessions were inadequate. The New South Wales Branch thought that conditions regarding rank were absurd—commissions were earned by men above the average standard; these men were

just those who should continue their medical studies, and they were to be penalized because of their attainments. The President said that these arguments had all been advanced by the Central Medical Coordination Committee. In the interests of the war effort it had been decided that the conditions should not be changed. The President did not think that the Council would get any further in the matter. Dr. C. Craig thought that big moves would soon be made by the A.I.F., and he did not think the army would let any of its officers go. Dr. H. C. Colville said that the Victorian Branch wanted the Federal Council to make further representations to the Minister. The absurdity of the position was obvious. Those who would come into this arrangement would have to be privates in lines-of-communication jobs. No further comment was necessary. After the President had stated his belief that the army would not release men who were of more use as soldiers than as doctors, the Federal Council resolved that it should make a further request to the Federal Government that suitable men should be released from the armed services in order to commence or continue their medical course, irrespective of their rank and station.

The General Secretary read a letter from the chairman of the Universities Commission. In this letter the chairman stated that students in the armed forces had always been considered for selection on the same basis as civilian applicants, and the practice during the past two years had been in marginal cases to give preference to applicants from the services. He added that the Universities Commission thought that it would be possible at the beginning of 1945 to give considerably greater preference to service men, by providing special quotas in which service men only might compete. If this could be arranged it would mean that the service man would be given "distinct preference over the present situation" and a considerably greater degree of preference than suggested by the Federal Council. It was decided that the Universities Commission should be thanked for its letter.

Contract Practice.

The Contract Practice Committee.

The Contract Practice Committee of the Federal Council was reappointed as follows: Queensland, Dr. C. P. Winterbotham; New South Wales, Dr. H. R. R. Grieve; Victoria, Dr. C. H. Dickson; South Australia, Dr. R. J. Verco; Western Australia, Dr. M. K. Moss; Tasmania, Dr. J. R. Robertson, together with the President *ex officio*.

The Federal Common Form of Agreement.

A communication was received from the New South Wales Branch enclosing a letter that had been received from the friendly societies of New South Wales asking for a conference in regard to the introduction of the Federal Common Form of Agreement.

Dr. T. A. Price gave a short account of the disagreement that had taken place between the friendly societies in Queensland and the Branch. He reminded the Federal Council that the capitation fee in Queensland varied with the basic wage index. He then explained that twelve months previously an approach had been made to the Prices Commissioner who had pegged the capitation fee at thirty shillings and sixpence, when according to the wage index it should have been thirty-two shillings. A meeting had been held with the Joint Committee of the Friendly Societies, and a resolution had been carried putting on the friendly societies the responsibility of making a further approach to the Prices Commissioner to leave the capitation fee at the proper level of thirty-two shillings. The trouble had been caused by the action of a few lodge secretaries and was an example of how a good service could be wrecked by a few persons. The argument used was why an increase should operate in Queensland when no increase took place in New South Wales or Victoria.

Dr. W. F. Simmons, reverting to the letter from the New South Wales Branch, said that the New South Wales Branch had agreed to meet the lodges, and would tell them that the Victorian Branch was waiting for a decision from the Prices Commissioner before the Federal Common Form of Agreement could be introduced. As a matter of fact the agreement would inaugurate a new service and its cost should be determined by mutual agreement.

As it had already been decided that the Federal Common Form of Agreement should be introduced as soon as possible, the correspondence was received.

The National Health and Medical Research Council.

The seventeenth session of the National Health and Medical Research Council was the subject of a report by Dr. W. F. Simmons, the Federal Council's representative on that body. Dr. Simmons said *inter alia* that when the representatives arrived at Canberra for the meeting they were told exactly when it would end. The main subjects discussed were venereal disease and the birth rate, and the medical heads of the services were present to take part. Other matters were not considered—they were just "wiped". This in Dr. Simmons's opinion was most unfair. He said that if he was to continue as the Federal Council's representative, he was not prepared to go to Canberra and be told before the discussions were held when he would leave to go home. Such a procedure was nothing but a waste of time. The report was received.

The Medical Coordination Committees.

At its meeting in May the Federal Council considered the transference of the Medical Coordination Committees from the Department of Defence to the Department of Health. After a long discussion the Council decided to address to the Acting Minister for Defence a strong protest against the transference and to ask formally that the original arrangement should be restored.

The General Secretary said that he had received from the Secretary of the Prime Minister's Department a letter dated June 27, 1944, in which it was stated that owing to the Prime Minister's preoccupation with urgent matters of defence, it had become necessary for powers conferred on him to be exercised by other Ministers. Actually, since August, 1942, the ministerial responsibilities in relation to the National Security Regulations under which the Central Medical Coordination Committee was constituted, had been undertaken by the Minister for Health acting for and on behalf of the Minister for Defence. After full consideration it had been decided that it would be more appropriate for the transfer to be complete. It was realized that the Central Medical Coordination Committee was a body set up as a wartime measure only. The *National Security Act*, 1939-1943, would continue in operation until a date to be fixed by proclamation, and no longer, but in any event not longer than six months after His Majesty ceased to be engaged in war. The Commonwealth Government asked for the full cooperation of the Federal Council and of the medical profession in the work undertaken by the Central Medical Coordination Committee. The President referred to a statement by himself that was prepared for publication with the approval of the Minister for Health and the chairman of the Central Medical Coordination Committee (Major-General S. R. Burston). This statement was published in The Medical Journal of Australia of August 26, 1944. Reference was also made to a letter addressed by the Queensland Branch Council to the Central Medical Coordination Committee, dealing with the whole question and written after receipt by the Queensland Branch of a letter from the General Secretary of the Federal Council.

The General Secretary said that he deplored the fact that the Queensland Branch had written to the Central Medical Coordination Committee a letter which should have gone through the Federal Council. He regarded this as a very serious error on the part of the Queensland Branch. The correspondence was received.

The Immunization of Children against Pertussis.

At its meeting in May the Federal Council discussed the possibility of combining diphtheria and whooping cough antigens in one preparation for immunization and decided to take the matter up with the Director-General of Health. The General Secretary had received a reply from the Director-General conveying information received from the Director of the Commonwealth Serum Laboratories. The preparation of experimental batches of a combined vaccine had been undertaken. The procedure was a modified form of that used by Kendrick and published in the *American Journal of Hygiene* of September, 1943. A considerable amount of special investigation was required before a batch suitable for tests in human beings was completed. Experiments were also being carried out at the Commonwealth Serum Laboratories in the preparation of a continued antigen "by mixing Diphtheria Prophylactic (alum-precipitated toxoid) with Pertussis Bacillus (phase 1) Vaccine (alum-precipitated)". A third investigation was proceeding, namely, the development of a pertussis bacillus (phase 1) vaccine (alum-precipitated) for general use. The reason why no less than three procedures were under review was that there was no uniformity in the procedures adopted by overseas manufacturers who were preparing combined antigens for immunization against diphtheria and pertussis. Mention was also made in the letter of the difficulties

attendant on the production of a combined vaccine which would be fully effective against both diseases.

It was resolved that a letter of thanks should be sent to the Director-General of Health for his reply.

The Advertising of Proprietary Medicines.

At its meeting in May the Federal Council considered action taken by the Newspapers Proprietors' Association in England in the control of advertisements of proprietary medicines in English newspapers. It was then resolved that a letter should be written to the chairman of the Newspaper Proprietors' Association in Australia asking that similar action should be taken by the Australian Press. The General Secretary reported that he had received a reply stating that a code in regard to the acceptance of advertisements by Australian newspapers had been in operation since 1942, and enclosing a copy of the code.

Insurance Companies and their Accident and Sickness Policies.

At the May meeting of the Federal Council attention was drawn to the inadequate list of diseases for which cover was given by Australian insurance companies in accident and insurance policies, and it was resolved that an approach should be made in the matter to the Fire and Accident Underwriters' Association. The General Secretary said that he had written to the association and had received a reply stating that an opportunity to discuss the matter would be welcomed. It was decided to allow the matter to stand over to the next meeting of the Federal Council.

The Unemployment and Sickness Benefit Act, 1944.

Attention was drawn by the Victorian Branch to clauses in *The Unemployment and Sickness Benefit Act*, 1944, dealing with certification and secrecy. Under the provisions of this act witnesses might be summoned to appear and to give evidence on oath and to produce documents. The act stated that witnesses should not fail to appear. Further, persons should not (*a*) refuse to be sworn, (*b*) fail to answer any questions, (*c*) fail to produce documents. No person was to divulge any information, but, notwithstanding this provision, might be compelled to divulge information if it was certified to be in the public interest that he should do so. The Victorian Branch held that these provisions were wrong.

It was pointed out in discussion that in regard to these provisions this act was identical with the old *Repatriation Act*. In the application of the latter act, however, the Repatriation Department protected the medical witness because it forwarded with the request for information the authority of the patient for the information to be given. It was resolved that in connexion with the *Unemployment and Sickness Benefits Act*, 1944, the Department of Social Services should be requested to follow the procedure adopted by the Repatriation Department in regard to information to be divulged by a doctor.

Commonwealth Employees' Compensation Act.

At the instance of the Victorian Branch consideration was given to the drawing up of a schedule of fees in connexion with the *Commonwealth Employees' Compensation Act*. Dr. H. C. Colville said that the matter was one in which the Federal Council should be interested. He referred to schedules of fees already in existence which had been drawn up between the bodies concerned and which were on a concessional basis. It was clear that if the Commonwealth could do so, it would use these lists and would take advantage of a concessional basis to which it was not entitled. Dr. W. F. Simmons said that as there were schedules in three States for Commonwealth matters, it would be wise to have a schedule of fees for the whole of Australia. It was resolved that a schedule of fees should be drawn up which was applicable to the treatment of employees who were entitled to benefits under the act. It was also resolved that Dr. W. F. Simmons should be empowered to draw up the schedule and that he should have powers of cooption.

Taxation: "Pay-As-You-Earn".

The General Secretary reported that he had written to the Commissioner of Taxation asking advice on certain aspects of "pay-as-you-earn" taxation as it affected *locum tenentes* and their principals. He pointed out to the Commissioner that the period for which a *locum tenens* might carry on the practice of his principal varied from part of a day to an indefinite length of time, but was generally in the region of two or three weeks. For periods under a week he was paid on a daily basis and for periods over a week he received a salary on a weekly basis with board and lodging free, generally at the doctor's home, but at times at a boarding house or hotel. The General Secretary said that he had asked the Commissioner of Taxation four questions as follows:

> 1. Will the principal, irrespective of the length of time that a *locum tenens* is engaged, be required to purchase stamps for the *locum tenens*, in accordance with the "Stamps Scheme"?
>
> 2. What value is to be placed on the board and lodging of the *locum tenens* for the purpose of the "Stamps Scheme", and will this vary according to whether the *locum tenens* lives at the principal's home or elsewhere?
>
> 3. What amount is the principal entitled to claim, in the way of a tax deduction, for the expenditure involved in providing board and lodging for the *locum tenens* when returning his income tax at the end of the year?
>
> 4. Should there be any circumstances under which the *locum tenens* is not called upon to pay under the "Stamps Scheme", what amount will he be required to show in his income tax return for board and lodgings?

A reply had been received. To the first question the answer was "yes". The answer to the second was one pound per week; it was pointed out, however, that if it was agreed that the value of such board and lodging was in excess of one pound per week, it would be advisable to use the higher value when calculating the tax to be deducted. The answer to the third question was, "the actual cost to the principal", and the fourth, "the estimated value to the *locum tenens*". The last paragraph in the letter from the Taxation Department was as follows:

> Although the principal can only claim the actual cost of providing board and lodging for the *locum tenens*, the latter must show in his returns the estimated value to him of the board and lodging provided. It is considered that the value of board and lodging provided in these circumstances would be in excess of £1 per week, and for this reason it is desirable that when calculating tax instalment deductions the estimated value should be adopted instead of the arbitrary value of £1 per week. If this course is not followed the tax deducted during the year will not be sufficient to pay the tax that will be assessed on the return lodged by the *locum tenens*.

The General Secretary said that he had also received a statement on the rebate of income tax for the year ended June 30, 1944. He had sent a letter on the subject to The Medical Journal of Australia for publication. The letter appeared in the issue of August 26, 1944, at page 220.

Publicity.

Dr. George Bell and Dr. W. F. Simmons were reappointed members of the Publicity Committee of the Federal Council.

The General Secretary then explained that he had discussed the subject of publicity with a well-known advertising agency which had prepared a statement on such publicity as the Federal Council might require. The statement, copies of which had been prepared and were in the hands of members of the Federal Council, dealt *inter alia* with public relations and what public relations would do and with means of presentation such as the Press, the radio, films, leaflets and pamphlets, and trained lecturers. The General Secretary explained that the cost of employing an advertising agency would probably be in the neighbourhood of £4,000 a year.

Dr. W. F. Simmons thought that the time had arrived for the establishment of an organization fund and pleaded for the adoption of a long-range view. It seemed, he added, that for a sum equal to less than one pound per member a regulated publicity campaign could be undertaken. He thought it would be a good investment to have such a campaign. The medical profession did suffer at the hands of the Press; its statements were often mutilated or so cut down as to be almost worthless. In the talks that he had had with medical practitioners in different parts of New South Wales, he had always told members that it would cost money to finance a publicity campaign. He therefore moved that a Federal organization fund should be established. Dr. C. Craig seconded the motion.

Dr. A. E. Lee said that the moulding of public opinion was necessary and that expert agencies were best suited to do this. He thought that if the money subscribed to such a fund could be allowed as an income tax deduction, there would be no difficulty about obtaining the money from

members. Dr. T. A. Price thought that the proposal was a dangerous one to adopt. It had been said that there was a great need for a campaign of the kind mentioned and the question had been asked whether the profession could afford it. Dr. Price held that the profession could afford it, but did not need it. Medical practitioners had all the publicity they needed through their own patients; they did not want publicity of the kind under discussion. Most propaganda was an efficient form of lying; the thing that really mattered was what they did to their patients.

Dr. C. Craig thought that any money to be used in an organization fund should be part of the Branch subscription. Dr. W. F. Simmons pointed out that a sum of £15,000 had been subscribed in connexion with national health insurance, and he thought that subscriptions to the fund should be voluntary. Dr. H. C. Colville said that there would be difficulty in raising money for vague and nebulous activities. A sum of £500 was available for publicity. It might be a good idea if an advertising agency would take the £500 and show what they could do as a sample. The President observed that it would be necessary to know what the money in an organization fund was for. Dr. C. Craig thought that the Federal Council ought to decide whether it intended to employ an advertising agency or not. Dr. George Bell asked whether the Council was agreed that it would be best to employ an advertising agency; he was not at all sure that it would. Dr. A. E. Lee said again that it was necessary to build up a favourable public opinion and that the expenditure of funds would pay in the long run. Dr. F. W. Carter said that the public wanted to know the case of the medical profession and that a start in stating the case could not be made too soon. Dr. H. C. Colville asked what did the Federal Council intend to publicize; it was essential to have some set ideas on that matter. The President remarked that the publicity committee would have to decide what should be done. The General Secretary said that the problem was difficult and he appreciated Dr. Colville's point of view. Members would want to know how the money was to be spent; that was a matter for the publicity committee. It was resolved that an organization fund should be established, and it was also resolved:

> That the Branches be informed of the decision of the Federal Council to establish an organization fund and of the purposes for which the fund is established and that they be invited to make contributions to such a fund.

It was also resolved that the Publicity Committee should be empowered to employ expert public relations officers to promote the policy of the Federal Council.

Organization of the Profession.

The General Secretary reported formally to the Federal Council that he had paid visits to the Tasmanian, New South Wales and Western Australian Branches of the Association.

Discussion in Committee.

At this stage the Federal Council went into committee and was joined, as previously determined, by Dr. H. R. R. Grieve and Dr. C. Byrne.

The Health Policy of the Australian Government.

In opening a discussion on the health policy of the Australian Government, the President referred to the origin of the committee of the Federal Council which was to meet the Government representatives on the afternoon of Thursday, September 28, three days later. He said that the committee was formed at the request of the Minister for Health, Senator J. M. Fraser, to meet representatives of the Government in order to formulate, if possible, plans for a medical service based on the policy that the service would be available to every member of the community without cost apart from taxation. He said that the three points that would have to receive special attention in such a discussion were the control of such a service, the conditions of service and the method of remuneration of those engaged in it. He added that conditions had changed since it was decided that the committee should be formed—the referendum on the granting of increased powers to the Commonwealth had been held and the increased powers had been refused. In the President's opinion the Federal Council should try to determine whether the Federal Government had power to institute a service and to give free medicine to the community.

The General Secretary said that the following had been appointed as members of the committee by the Branches in the several States: Dr. A. E. Lee (Queensland), Dr. H. R. R. Grieve (New South Wales), Dr. Charles Byrne (Victoria), Sir Henry Newland (South Australia), Dr. F. W. Carter (Western Australia), Dr. C. Craig (Tasmania). He said also that he had had some correspondence with the Minister. He mentioned that in his letter to the Minister he had used the phrase "erect the structure" of a medical service in connexion with the discussions of the committee. The Minister had replied that it was the duty of the Government alone to "erect the structure"; what he desired of the committee was a full discussion on the practical aspects of the government policy with the object of arriving at unanimity. The meeting of the committee was to have taken place at Canberra, but the General Secretary had pointed out that the Federal Council was meeting in Melbourne at the time proposed for the meeting and that the cost and inconvenience would be less if the committee were to meet at Melbourne. The meeting would therefore take place on the following Thursday afternoon.

The General Secretary said that in the common letter to the Branches in which he had asked them to inform him of the name of the representative chosen for the committee, he had asked to be advised on two points. The first was whether the members of the Branch would be willing to participate in the working of a medical service which was available without cost to every member of the community, subject, of course, to conditions of service of medical practitioners being satisfactory. The second was designed, if Branch members were willing to participate in such a service, to discover the views of the Branch in regard to (*a*) the form of administration; (*b*) the form of contract, including method of payment, between the Government and the medical practitioner.

In its reply the Tasmanian Branch stated that it considered that health was not mainly a question of medical services. The public should not be misled into believing that good health depended mainly upon hospitals, clinics, doctors, bottles of medicine, or indeed organization, but on sufficient hospital accommodation, sanitation, water supply, housing, nutrition, conditions of work, facilities for recreation, maternal and child welfare, tuberculosis control and preventive medicine generally. The Tasmanian Branch agreed with the Federal Government's aim to secure for everyone all the advice, treatment and care they required in the matter of health, but was firmly of the opinion that no drastic change such as was suggested by the Government should take place until the service medical officers were able to take part in the deliberations. The Branch considered that the Federal Government, after discussion with the six members, should draw up a detailed proposal such as the British Government had done in its White Paper, and that this should be considered by the whole profession before it was embodied in an act of Parliament. While the Branch recognized that the control, broad policy and finance must remain with the Government, it regarded it as essential to the satisfactory working of any such service that detailed administration should be in the hands of an executive body, the majority of whose members should be appointed by the organized profession. Of the various methods of payment that had been suggested, the Branch thought that the fee-for-service principle would be preferable if a proportion of the total fee was paid by the patient, but that, if complete freedom from direct cost had to be accepted, further consideration should be given to the view that a capitation system would involve least disturbance of existing practice and least control of or interference with doctors. A salaried service would not be acceptable to the profession.

The South Australian Branch had replied that at the conference with the Government stress should be laid on the necessity for the Government to bring out a White Paper for transmission to the profession throughout Australia. The Branch also held that, as the government scheme for a free service was not complete, as its proposals were still tentative, negotiations with the Government should still be carried on.

The reply of the New South Wales Branch took the form of a series of resolutions adopted at a convention of the Branch held on September 8, 1944. In the first resolution the convention reaffirmed the constructive policy of the Federal Council as meeting the public need and emphasized the view that preventive measures should receive the early attention which their importance warranted. The second resolution stated that as the government policy had been stated as a free policy to every member of the community, with control by a government department and a contract for service between the Government and the doctor, the convention was agreed that such a policy was not in the public interest and was not acceptable to the members of

the Association. The main basis of the objection was that the regimentation both of patients and of practitioners, inseparable from and essential to any government scheme of free curative medical and hospital service departmentally controlled, was inimical to maximum efficiency and public confidence. The third resolution stated that no general medical service scheme was acceptable to members of the Association which did not maintain the existing doctor-patient relationship. In the fourth place the convention considered that the medical profession should not, except in cases of emergency, render honorary service to patients in public wards and out-patient departments who could afford to pay for intermediate or private treatment. The convention's last resolution stated that the notice of the Government should be drawn again to the fact that there was a dangerous deficiency in all classes of hospital accommodation and that no scheme to improve the health of the community could succeed unless adequate hospital services were provided.

The Victorian Branch replied that its members would be prepared to accept a scheme for a complete medical service, available without cost to every member of the community, only if it was conducted in accordance with the resolutions adopted at the meeting of convocation in January, 1944. (See The Medical Journal of Australia, February 26, 1944, page 184.) The Victorian Branch went on to state that its views on administration were also covered by the resolutions of convocation. It added that in its opinion the Government had proposed an unacceptable scheme for a nation-wide medical service, and that the only acceptable form of contract with the Government would be a broad general agreement covering schedules of fees and cognate matters.

The Western Australian Branch replied in terms of resolutions adopted at the meeting of convocation on July 30, 1944. In its first resolution the convocation stated that it was in favour of a general medical service available to all, irrespective of income and under government financial control. At the same time it explained that the Branch held that any scheme wherein some direct payment was made by the patient was preferable to the free-for-all service proposed by the Government. In its second resolution the convocation stated that the form of administration should be in the hands of a corporate body directly responsible to Parliament through the Minister, and that the practising profession should be adequately represented on this body by representatives elected by members of the profession practising curative medicine. The resolution further stated that if the Government refused to accept these terms, the profession would be willing to accept service if a strong advisory body was formed with the constitution and the powers suggested by the Parent Association and described in the *British Medical Journal* of May 13, 1944. Such medical representation should constitute a majority. The Branch held that the payment for service should be on a fee-for-service basis, except where the corporate body considered that a salaried service or alternatively a *per capita* method of payment would render a more efficient service to the public. It was thought that it was not possible that any one form of contract would be adequate for the whole of Australia. Further, no salaried or capitation basis of payment should be inaugurated in any district until sufficient medical practitioners were available to man the service efficiently. It was held that any planning by the Government should be undertaken in close cooperation with the practising profession and not separately by a government department. The Western Australian convocation's final statement was that though it approved of planning for the future, no agreement should be made with the Government without full consultation with medical practitioners on active service.

The Queensland Branch, in its reply, reaffirmed the view that a salaried basis for a nation-wide service was not in the best interests of the community, and was therefore not acceptable to the medical profession. It also expressed the opinion that if a general medical service was introduced, an income limit should not be imposed.

The General Secretary said that the Federal Council might discuss the powers of the Federal Government to introduce a medical service. He pointed out that the Government had no such power and added that it had been suggested that it might adopt the expedient of using grants-in-aid to the several State Governments on some prearranged plan. He also suggested that it was important to determine at the outset whether the medical profession would accept a service with 100% availability.

The Federal Council then discussed in committee the terms of reference for the committee of six who were to meet representatives of the Governmnt.

Dr. A. E. Lee said that the first question that should be raised was the legal basis of the proposed service. It might be stated that the service would be presumed to be legal because no one felt disposed to suggest that it was illegal. No one had questioned the legality of the *Maternity Allowance Act*, or even of the Commonwealth Department of Health itself, though he understood that both these were *ultra vires* the constitution. In the second place the question might be asked whether, the present commitments of Parliament in regard to the Social Benefit Fund being kept in mind, there was any prospect of the Government's ability to finance a medical service from these funds. An important leading article had recently been published in *The Sydney Morning Herald* on this subject, and it was clear that if the Government saddled itself with a medical service, it would not have the slightest possibility of being able to finance it. The committee should point out to the government representatives that the medical profession had solutions to all the Government's proposals in regard to finance, the part the Government should take in a service, and certain problems of the content of medical practice. In the third place the profession had views of its own which should be put forward. The final question was whether the members of the medical profession would want to serve in a governmentally controlled service. The majority of practitioners in Queensland were not willing to take part in such a service.

Dr. H. C. Colville said that he presumed the procedure was to arrive at resolutions which would form the instructions and the terms of reference for the committee of six. He then referred to the Government's proposals as expressed in the agenda at the recent Canberra conference—all members of the community were to benefit; the service was to be free to everyone, except for payments made in taxation; there was to be a direct contract between the Government and the doctor; and administration by a department was necessary. The reactions of the medical profession to these proposals were definite. As individuals, medical practitioners would first ask what it was all about. Was there any outcry or demand to have the present system of medical practice scrapped? Was there any evidence that it had been tried and found ineffectual? Was there any evidence that a change would improve the health of the community? The reply would be that there was no justification for the proposed change. It was apparent that the Government's proposals were contrary to the profession's ideas of the improvement of the medical services to the community. The formation of policy was against the resolutions of the Federal Council, particularly in regard to the introduction of change during the war or for one year after its conclusion. The sum total of the profession's reaction was that the Government's proposals were unjustified, unsatisfactory and not worthy of support. Dr. Colville was surprised that such a view had not been expressed at the Canberra conference. The policy of the Federal Council had not been voiced at the conference. There was now an opportunity to voice the policy. Two courses of action were open. Which course should be adopted depended on whether the Government's proposals were inevitable or not. Dr. Colville went on to explain the reasons why he thought that the Government's proposals were not inevitable, but were merely a statement of certain intentions. He held that it would not be possible for the Government to carry them out in opposition to the Federal Council. A threat had been uttered by Ministers, but there was no need to take it seriously. Dr. Colville then foreshadowed some motions which he intended to move later on in the discussion.

Dr. C. Craig congratulated Dr. Colville on his clarity and realism. He differed from Dr. Colville in his view that there was no call for change in medical practice. There was an outcry against the sums of money that had to be paid to doctors. Fees were actually far above the capacity of the average Australian to pay. He had talked with patients and they had all agreed that the cost was too high—he was referring, he said, to those with incomes around the £500 a year mark. They all knew that persons who had to submit to surgical operation and pay fees never managed to "get out" under a sum of £30. Fees should be shared between the whole community. The problem was how they were to be shared, and Dr. Craig could not see how this could be done without a government scheme.

Dr. F. W. Carter said that in Western Australia there was a demand for a service that was more easily paid for than at present. The voluntary schemes had failed because they could not be applied to the whole community. The country was at liberty to insure itself in regard to all the hazards of life and people should be helped to do this. In reply to a question from Dr. Grieve whether he spoke in

the light of the fact that the Government's policy was not an insurance policy but to provide a free service, Dr. Carter said "yes", but added that the Government might be persuaded to change its policy.

Dr. H. R. R. Grieve said that he had heard sufficient discussion in different parts of Australia to grasp the different opinions. Apparently the Federal Council did not realize sufficiently that the profession had to deal with many different schemes. They were face to face with reality. The Government had its policy and the stage at which theories might be elaborated had passed. The relative merits of the different schemes should be determined. The Federal Council had to decide what it thought of the government policy. The Council had never gone back on certain principles. It refused to have control by a government, and the Government said that there must be control by a Minister; there must be a contract. There was nothing else to be known. The question was whether the members of the Federal Council would be true to themselves or not. If they gave in, he, Dr. Grieve, would not be with them. How could they go to a government and say that they would go on discussing? Dr. Colville had asked that question, and he himself had asked it at Canberra. How could they temporize any longer? The Government was only bluffing. They had not one atom of power to do what they talked of doing. In theory they might work by cooperation with the States, but the Government in New South Wales was one government which would not operate such a scheme. The Federal Council should be practical.

In reply to a question by Dr. Craig as to what he thought of control by a corporate body, Dr. Grieve said that there was danger in it. He had heard various terms used to describe the ideas of members in this regard. The term corporate body had graduations of meanings, but the Government was definite in its statement that it must have control. All bodies like corporate bodies derived their control from the Crown. Experience had shown that once power was given by the Crown there was always a tendency for the Government to whittle it down and to assume control. An advisory body gave advice, but it was never satisfactory because the advice was never followed—the government policy was followed. As an example Dr. Grieve referred to the Australian Broadcasting Commission. This body had been given an ideal constitution and men who had knowledge and ability were appointed to it. Gradually the powers of these men had been whittled down until the Commission was at the present time a means of government. There was no such thing in Australia as political independence. The medical profession had to fight, though many of its members were reluctant to do so.

Dr. N. M. Cuthbert asked about the control of an insurance scheme. Was the idea of insurance to be abandoned? Had they to sit tight forever and not put out a scheme for the nation? There must be some suitable scheme, and he was in favour of an insurance scheme.

The General Secretary referred to the Metropolitan Hospitals Contribution Fund of New South Wales, and said that it arose because of a desire to undertake hospital prepayment.

Dr. F. W. Carter deprecated talk about lack of courage. He believed that there was a call from people who wanted to pay for medical treatment. Though the medical profession would not agree with the Government, it would have to agree with a scheme that would help people to pay.

Dr. W. F. Simmons said that the Federal Council was agreed that the undefined middle class group could be covered—this did not include the 2% of people who were able to afford full private fees.

Dr. F. L. Davies referred to the attitude of the Federal Council at Canberra and said that it would have been wrong to retire from the discussions. Any false move made by the Federal Council would have been used to the Government's advantage. The Government could now be told what the Federal Council thought. Dr. Davies did not think that insurance offered a solution to the problem. Propaganda had been discussed, but so far nothing had been done about it.

Dr. T. A. Price said that the Government had a dual motive. It had an honest purpose in bringing a complete medical service to the people, and it included everyone in the community because the 2% who could pay full private fees were negligible. The Government also wished to make political capital. It was the departmental officers who had given the politicians their ideas. They were the background of the whole business. The most important point was decentralization on a district basis. After discussing this aspect in relation to decentralized control, Dr. Price suggested that the profession should go to the Government and work out a service scheme on an insurance basis.

Dr. R. J. Verco discussed the ability of the public to pay fees. He said that they could pay. In his practice 90% of patients had their operations done and only a small proportion failed to pay. There was something wrong with the idea that the average Australian could not pay his medical expenses.

Dr. A. E. Lee said that many young people belonged to the 98% group that had been mentioned. He thought that if the proposed Commonwealth grant of six shillings a day for hospital expenses was actually introduced, many public hospital wards would be empty.

Dr. F. W. Carter referred to the use of a model lodge agreement and asked Dr. Colville and Dr. Grieve what they thought of an amplification of lodge powers and services and how such an amplification could be achieved. Were they prepared to hand over a full service to the control of the lodges? What he really wanted to know was how it was proposed to relieve the public. Dr. H. C. Colville replied that he had given no thought to the question which was only remotely related to the proposals before the meeting. In reply to an interjection regarding a cut and dried government policy, Dr. H. R. R. Grieve said that the government policy was cut and dried. It was only necessary to read *Hansard* to realize that. He had never thought that friendly society services should be extended. The friendly societies had done a good job of work, but it was possible to run a good service without them. Dr. Grieve went on to explain that the Metropolitan Hospitals Contribution Fund which operated in Sydney covered seven-eighths of the metropolitan population. The persons controlling this fund were willing to run a medical service in New South Wales, and this could influence the whole of Australia. Dr. Grieve was not in favour of wider powers for friendly societies.

The General Secretary referred to "negotiations" with the Government. He reminded the members of the Federal Council of what had happened to their negotiations in the past. Negotiations had been conducted about the pharmaceutical bill, about certain service matters with the Repatriation Department, about tuberculosis and so on, but the Federal Council's representations had been consistently ignored. It was ridiculous to be "led up the garden path" again. The Government would pay no heed to the representations of the medical profession.

Dr. C. Craig referred to the view that no negotiations should be conducted with the Government, and said that he hoped the medical profession would not be undignified. The British Medical Association, as it was, was regarded by the public as a "big bad wolf", and this view would not be altered if the profession refused to negotiate. They should walk with circumspection and should be prepared to negotiate. After referring to the value of the radio talks given on health matters by the "B.M.A. Spokesman" and to the fact that they were welcomed by the public, Dr. Craig said that it would be good if the activities of the Hospitals Fund mentioned by Dr. Grieve could be expanded. He asked whether it would be possible to do so and to have a central body for the whole of Australia. The drawback of a privately run scheme was that every person in the community could not be brought into it. In conclusion, Dr. Craig said that when they met the Government they should be reluctant to break off negotiations, but they might have to do it.

Dr. C. Byrne said that after the earlier part of the discussion he had been bewildered because so many divergent views had been expressed with so much sincerity and so much truth that every speaker had almost convinced him. He realized that this was because every speaker spoke almost the whole truth. He had set himself the difficult task of trying to find common ground in the views. If those present could not achieve unity, to ask the five thousand practitioners in Australia to do it was like trying to drink the ocean dry. Dr. Lee had put forward suggestions that the Government should be asked the legal basis of its proposed service and how much money was available to finance it, that the Federal Council scheme should be urged on the government representatives and that a contract between the Government and the medical practitioner was unacceptable. Dr. Byrne agreed with these suggestions. Dr. Lee had then stated that the present empty obstetric wards were a sign that help was not needed by the people. Dr. Byrne thought that this fact showed that a government subsidy had worked and would work. He had agreed with most of Dr. Colville's remarks. He pointed out, however, that Dr. Colville had not carried his argument to its logical conclusion. Dr. Byrne also agreed

with much that Dr. Grieve had said. Dr. Grieve had said that political influence crept into the working of organizations controlled by a corporate body, in much the same way as the Government might interfere with the running of hospitals and so on. He had, however, given no instance in which employees had been subjected to political influence. (Dr. Grieve interjected that he could do so.) Dr. Byrne went on to say that he interpreted Dr. Simmons's views as suggesting that the solution for the lower income groups was to make them all lodge patients. Dr. Byrne looked on this as far from ideal. Dr. Craig claimed that there was a class of patient who found the payment of medical fees a heavy burden. Dr. Verco, on the other hand, said that patients paid, but the number of those who did was becoming less and less. In order to show that though patients could pay fees, it was a big strain on them to do so, he quoted figures taken from his own practice which showed the income of patients and the fees which they paid for surgical procedures; none of the patients could be regarded as being in the public hospital group. Dr. Byrne found that all the speakers were agreed on the following points: (*a*) the Government should be asked what was the legal basis of its proposed service; (*b*) the Government should be asked where the money was to come from to pay for the service; (*c*) a protest should be entered against the introduction of a scheme during the war; (*d*) the policy of the Federal Council should be urged and cooperation should be offered in the bringing about of certain improvements in practice; (*e*) it should be made clear that no scheme was acceptable which did not preserve the existing doctor-patient relationship; (*f*) government control and the drawing up of a contract with the practitioner should be declared unacceptable. Dr. Byrne then stated that apart from the fact that the Government envisaged a service which was to be free to everyone, the three problems that confronted the medical profession in the government scheme were the method of remuneration, departmental control and the drawing up of a contract. In a memorandum which Dr. Byrne had circulated among members of the Federal Council before the meeting he showed that these three problems were to a large extent interdependent. He explained that the fee-for-service system was the only one which would allow the elimination of all contracts. He argued that freedom from control necessitated (*a*) a fee-for-service method of remuneration, (*b*) the avoidance of contracts, and (*c*) no connexion with cash benefits. The next fundamental requisite was, he stated, that the patient and not the State should employ the doctor. In no other way could the personal doctor-patient relationship be maintained. Dr. Byrne referred further to the scheme elaborated by himself and said that, though he did not think the Government would accept the scheme, if it was put up to the Government, it would at least show that the profession was not adopting a dog-in-the-manger attitude.

Dr. H. C. Colville said that he wished to reply to Dr. Byrne, who had stated that his (Dr. Colville's) proposals were incomplete. This Dr. Colville denied. It was, he declared, inadvisable to enter into details until the first step had been taken, and the first step was surely to determine whether the Government's proposals were inevitable or not. The General Secretary had referred to the results of attempts to influence the Government. The present matter was quite a different proposition from anything that had gone before. It was different from the question relating to the coordination committees; it was different from the problem surrounding the *Pharmaceutical Benefits Act*. In both these matters the Government had been able to carry out its intentions without the cooperation of the medical profession. The Government could not put its scheme for a medical service into effect without the cooperation of the profession. Dr. Colville held that the Government's proposals were not inevitable.

The President said that he thought the Government's proposals were inevitable, though he did not think that a 100% service of the profession would result. A Government policy of a free medical service with free medicine would probably be instituted in lesser degree only; any attempt to do so on a large scale was doomed to fail. It had been decided that doctors should be placed in outlying districts and be paid either by subsidy or by salary, that hospital services should be extended, that diagnostic centres should be multiplied and the practice of industrial medicine increased. Medical staffs would have to be found in connexion with all these branches of medical enterprise and financial arrangements would have to be made for their running. It should not be forgotten that the medical profession in its planning had to look after the interests of those who would serve on these staffs.

Dr. H. R. R. Grieve said that he could not accept the President's view. There was no justification for the statement that the Government's proposals would be carried out. The President had stated that the Government would carry out certain items of its policy, that it would enter the field of industrial medicine and so on. These forms of government activity were different from what was connoted by a government medical service. There was a line of demarcation, and as a matter of fact in the Federal Council's policy such matters as public health and industrial medicine were looked on as coming within the range of a government function. The extension of government activity in these directions did not make a government general service more inevitable. Dr. Grieve thought that Dr. Colville's formula would cover what was needed, and Dr. Grieve was not afraid of public opinion if the Federal Council did what Dr. Colville suggested. The attitude was not a selfish one; it was in the interests of the public. There was no doubt that the preservation of the doctor-patient relationship was in the interest of the public and the public would accept this.

The President said that he was unrepentant in his view that the government proposals were inevitable. The Government would introduce a bill for the provision of a medical service, and the crucial time would come when the Government had its act and asked for the cooperation of the medical profession.

Dr. H. R. R. Grieve pointed out that the question of a government medical service had never been before Caucus, and it was reported that even the Prime Minister had an open mind about it.

Dr. W. F. Simmons said that pharmacy benefit and hospitals benefit were mentioned in the government estimates. The medical profession should say that it was opposed to a medical service. If the Government wanted cooperation it should set out its views in a White Paper as Great Britain had done. Dr. Simmons thought that the Federal Government was dishonest and did not want cooperation.

Dr. George Bell said that he came into contact with men in the services, and the criticism generally offered by them was that the medical profession had no plan. He had felt with Dr. Byrne that a fee-for-service scheme would preserve the independence of the patient. In regard to financial control of a medical service, Dr. Bell said that once the Government had control it would keep the service under a department.

The General Secretary referred to a draft final report on the fee-for-service system operating in New Zealand, published recently as a supplement to *The New Zealand Medical Journal*, in which the defects were emphasized and the view was expressed that the service should be discontinued. The General Secretary reminded members that the New Zealand system was a refund system—the doctor collected his fee (a specified fee) from the patient and the amount was refunded to the patient by the Government.

Dr. C. Byrne pointed out that the New Zealand report was contradictory. First it showed that the system lent itself to abuse and then it went on to prove that the cost was actually less than was expected. In New Zealand the idea was that part of the fee should be paid by the patient, and this was what the Victorian Branch had in mind.

Dr. F. W. Carter referred to the suggestions that the legality of the Government's proposals should be questioned and that information should be sought on the source of the money that would finance the project. Dr. Carter deprecated the raising of either of these questions.

Dr. H. R. R. Grieve agreed that Dr. Carter's contention was wise.

Dr. H. C. Colville then proceeded to move a series of five motions. He said that he regarded them as a complete entity and thought that they should all be passed. He therefore moved:

> That the duties of the Committee of the Federal Council appointed to meet representatives of the Government shall be as follows:
>
> To enter an emphatic protest against the formulation by the Government of a scheme involving a drastic alteration in the form of medical service to the community during the war or for one year afterwards.

Dr. Colville said that it was a primary duty to advocate something on these lines as an obligation to men on service. The activities of the Government would concern the younger generation of practitioners much more than they would concern practitioners such as those comprising the Federal Council. There was a large and growing number of young men who had necessarily been quite inarticulate. It was the barest duty of the Federal Council to see that no

changes were introduced until these men had had an opportunity to discuss them.

Dr. George Bell seconded the motion. It was, he said, the most important of all the motions.

Dr. A. E. Lee moved as an amendment that the words "for one year after the proclamation of the termination of hostilities" should be substituted for "during the war or for one year afterwards". Dr. T. A. Price seconded the amendment. Dr. C. Craig opposed the amendment and pointed out that as long a period as three years might elapse between the declaration of an armistice and the proclamation mentioned. Such a suggestion made the motion a mockery. Dr. F. L. Davies thought that the wording used should be the same as was used in national regulations. Dr. H. R. R. Grieve pointed out that the men might not come back home for some considerable time. The amendment was put to the meeting and was lost. Dr. Colville's motion was carried.

The second motion moved by Dr. H. C. Colville stated another of the duties of the committee appointed to meet the government representatives as follows:

> To make a formal request that such a scheme shall not be formulated during the specified period.

The motion was seconded *pro forma* by Dr. C. Craig, who asked whether the word "formulated" was the right word to use. It was explained that the introduction of a measure such as that under discussion occurred in three stages—discussion, formulation and implementation. A scheme was formulated when a bill was drafted. The motion was carried.

Dr. H. C. Colville's third motion, which was seconded by Dr. George Bell, stated a third duty of the committee appointed to meet the Government and started with the words "In the event of this being refused". To these words Dr. C. Craig objected. The General Secretary said that he could see Dr. Craig's point of view—that the duty of the committee should not be conditional. Dr. H. C. Colville agreed to the exclusion of the words objected to, and, the permission of the meeting having been given to their exclusion, the motion was put and carried in the following form:

> To inform the Government that the government policy having been stated to be a free medical service to all, with control by government department and a contract for service between the Government and the doctor, the Federal Council is agreed that such a policy is not in the public interest and is not acceptable to the Federal Council.

The Federal Council then adopted Dr. Colville's fourth motion setting out another duty of the committee as follows:

> To offer the Government the fullest cooperation of the Federal Council in bringing about any of the following improvements in the medical service to the community:
>
> A. Maternal and child welfare.
>
> Since the security and prosperity of Australia depend upon a rapid and progressive increase in the indigenous population, we strongly urge that everything possible should be done to encourage people to marry earlier and have larger families. This should result if the Government gave a clear lead by providing better housing facilities, by ensuring that there is available to every mother and child a daily sufficiency of the protective foods, by financially assisting those prepared to undertake parenthood, and by making provision to improve the amenities and lessen the drudgery of family life.
>
> To give this policy concrete shape the Federal Council recommends the Government to subsidize, through the State Governments, the provision daily to each child attending school a luncheon of the type and nutritive value of the Oslo lunch.
>
> We would stress also the importance of better supervision of the mental and physical health of every child from birth to adult life. There should be a much greater availability and wider use of day nurseries, crèches and kindergartens, the provision of a greatly increased number of spacious playgrounds, and careful medical supervision of school children for evidence of undernutrition, nervous instability and other minor departures from health, and more extensive immunization against diphtheria, whooping cough and other diseases from which protective immunity may become possible.
>
> We regard these matters as the most urgent health needs of the Commonwealth at the present time.
>
> B. Problem of tuberculosis.
>
> (See page 12, sixth "Interim Report of Parliamentary Joint Committee on Social Security").
>
> A living wage allowance to tuberculous breadwinners and greatly increased facilities for diagnosis and treatment of tuberculous sufferers, including the construction of sanatoria.
>
> The Federal Council, like the National Health and Medical Research Council, has from time to time directed the attention of governments, both present and past, to the urgent need of dealing with this problem.
>
> C. Construction and extension of hospitals, including addition of pathological laboratories, X-ray departments, and all facilities for efficient diagnosis and treatment of injuries and disease, according to a decentralized plan.
>
> There is a glaring deficiency in accommodation for subacute and chronic diseases.
>
> D. Extensions under the present control of the Flying Doctor Service, including aerial nursing services, aerial ambulance transport, X-ray, pathological and other aids to efficient diagnosis, to be carried for patients in the outback.
>
> E. Increased subsidized medical practitioner service to outback areas.
>
> F. Increased grants, through present agencies, for post-graduate education.
>
> G. Subsidizing popular medical education.
>
> H. Grants to the universities in aid of the teaching of and research into industrial medicine so as to improve the health of and increase the measure of safety to the worker.
>
> I. Recent changes in the form of treatment of the most common type of venereal disease underlines the importance of maintaining secrecy in relation to this complaint by allowing and if necessary subsidizing treatment under ordinary practice conditions, away from venereal clinics.
>
> J. Adequate provision for research, preferably a permanent annual sum. At present the period and the amount of the annual grant are liable to be varied at any time.

Dr. Colville's fifth motion, seconded by Dr. F. W. Carter, stated yet another duty of the committee appointed to meet the government representatives. The motion was adopted in the following terms:

> To inform the government representatives that the Federal Council will be willing to discuss any scheme put forward by the Government for the expenditure of public money on the provision of financial relief for individuals arising out of illness in which the following conditions are observed:
>
> A. That the negotiations shall not proceed beyond the stage of discussion until one year after the war.
>
> B. That the scheme should retain the existing doctor-patient relationship.
>
> C. That the scheme shall be free from departmental or any other method of control which would interfere with the freedom of the profession and the public.

Dr. Byrne thought that the committee appointed to meet the government representatives should raise the question of the patient's taking a share in the financial responsibility for his illness. He moved a motion stating that in any scheme a patient should retain some financial responsibility.

Dr. A. E. Lee opposed this view. He said that the Federal Council had used the words "moral and social responsibility". The insistence on a share in the financial responsibility was a weakness in Dr. Byrne's scheme, for the indigent were quite unable to shoulder such a responsibility. Dr. W. F. Simmons supported Dr. Lee. Dr. T. A. Price pointed out that moral and social responsibility did not necessarily involve a question of money. The Western Australian representatives put the view of their Branch that the patients should pay something when it was possible for them to do so. The General Secretary suggested the use of the words "unless his financial circumstances so precluded". Dr. A. E. Lee did not like this, as it meant the introduction of a means test. The motion was adopted in the following form:

> To inform the Government that the Federal Council considers that in any scheme the individual, unless his financial circumstances so preclude, should retain some share in the financial responsibilities of his illness.

The Drawing up of a White Paper.

Dr. C. Craig then moved and Dr. J. S. Reid seconded a motion to the effect that the Federal Council suggested that the Federal Government with the help of the British Medical Association should draw up a White Paper on the subject of a medical service.

Dr. W. F. Simmons said that in Great Britain the Parent Body had had no hand in the preparation of the White Paper; but the General Secretary pointed out that the Parent Body had had something to do with the preliminary stages. Dr. H. R. R. Grieve pointed out that White Papers had always been statements of government policy or collections of documents bearing on government policy. The proposed move would imply that the Association approved of the White Paper. It was the Government's duty to publish White Papers, and as a matter of fact the Federal Government had issued what was to all intents and purposes a White Paper. Dr. H. C. Colville said that the motion suggested that the Federal Council should ask the Government to formulate a scheme when it did not want the Government to do such a thing. The attitude for the Federal Council to adopt was that if the Government persisted in formulating a scheme it should at least allow the Federal Council to see it. Dr. F. W. Carter was opposed to any move which would suggest that planning was not to proceed. Dr. W. F. Simmons pointed out that the Government would not consult the profession in any case. The National Health and Medical Research Council was the Government's advisory body. Dr. H. C. Colville asked what Dr. Craig had in mind, and the latter replied that he envisaged a White Paper issued by the Government after it had heard the views of the profession. Dr. N. M. Cuthbert said that it was the duty of the Federal Council to inform the Government that it had been wrongly advised—the members of the practising profession were the experts in curative medicine. Planning should go on so that a plan would be drawn up by the time service members returned to civilian life. The President reminded members of the promise of Mr. Holloway, a previous minister for health, not to introduce a scheme until the end of the war. Dr. H. C. Colville said that he did not know what Dr. Craig and Dr. Cuthbert had in mind in regard to planning with the Government, but he referred to the motions already adopted and pointed out that the Federal Council was not closing the door on discussion. After further discussion the motion was put and was rejected.

A Voluntary Insurance Scheme in New South Wales.

Dr. A. E. Lee asked whether the committee might be asked about finance in relation to schemes for medical service. He thought that the Government should be shown that there were schemes other than the one which it advocated.

Dr. C. Craig moved that Dr. Grieve should be empowered to describe to the representatives of the Government the scheme for voluntary insurance envisaged by the New South Wales Metropolitan Hospitals Contribution Fund. Dr. George Bell seconded the motion. Dr. H. R. R. Grieve said that the committee should not be fettered in the discussions with the Government, but that its views should be expressed in terms of known policy. He thought that it would be useful if he was able to do as Dr. Craig suggested. The committee should be able to mention any constructive policy that it had. The motion was carried.

A Report of the Conference with the Government.

It was resolved on the motion of Dr. N. M. Cuthbert, seconded by Dr. C. Byrne, that a request should be made to the Director-General of Health that a full report of the conference on September 29 should be made. It was subsequently learned that the Director-General had stated that such a report could not be prepared.

Hospital Services.

The General Secretary reported that he had written to the Branches in regard to the hospital subsidy which was to be paid to the several States following on their acceptance of the Commonwealth Government's scheme for hospital benefit with consequent abolition of the means test. He had stated in the letter that the continuation of the honorary system was to be discussed by the Federal Council at its meeting. He had asked the Branch Councils for their views on the matter and had suggested that, if they decided that the visiting staff of hospitals should be paid, they should state what the rates of payment should be. For the information of the Branches he had got out the rates of payment made to visiting medical officers of the Brisbane and South Coast Hospitals Board and also the rates of payment laid down by the representative body of the British Medical Association for medical practitioners employed on a sessional basis.

The following is a statement of the rates of payment made to visiting part-time medical officers of the Brisbane and South Coast Hospitals Board.

Four senior physicians, four junior physicians, four assistant physicians (each three sessions per week).
Three senior surgeons, three junior surgeons (each four sessions per week); three assistant surgeons (each three sessions per week).
Two senior gynæcologists (each four sessions per week); two junior gynæcologists (each three sessions per week).
One senior orthopædist (four sessions per week); one senior urologist, one junior urologist, one assistant urologist (each two sessions per week).
Two senior ear, nose and throat surgeons, two junior ear, nose and throat surgeons, two assistant ear, nose and throat surgeons (each three sessions per week).
Two senior ophthalmologists, two junior ophthalmologists, two assistant ophthalmologists (each two sessions per week).
One senior radiologist, one radium therapeutist (each two sessions per week).
One senior psychiatrist (two sessions per week); one dermatologist (two sessions per week).

Each session is of three hours' duration except in the case of the assistant ophthalmologist, whose sessions are two hours.

The annual salaries of each position are based on the number of sessions as set out above, the scale per session being £3 10s. for seniors, £2 10s. for juniors and £2 for assistants; for sessions of two hours' duration the rate is £2 10s., £2 and £1 10s. respectively.

When any alteration is made by the medical superintendent in the number of sessions, payment is made *pro rata*. For example, if one senior physician has two sessions per week instead of three, he would be paid at the rate of £7 per week instead of at the rate of £10 10s.

The rates of payment laid down by the representative body are as follows:

For consultant and specialist work at hospitals or clinics (including the administration of anæsthetics, treatment of venereal diseases, and X-ray examination and treatment), remuneration on the following scale:

(*a*) For regular sessions where the method of payment is by salary then:

	Not less than
	£
Where not more than one regular attendance or session per week is required of not more than two hours' duration	125 p.a.
Where two regular attendances or sessions per week are required	200 p.a.
Where three regular attendances or sessions per week are required	275 p.a.
Where four regular attendances or sessions per week are required	350 p.a.
Where five regular attendances or sessions per week are required	425 p.a.
Where six regular attendances or sessions per week are required	500 p.a.

(*b*) Where an individual, additional, or occasional consultative, or specialist's session of not more than two hours' duration is required, the remuneration should be not less than £2 12s. 6d. per session.

(*c*) If emergency attendances are required, the fee should bear suitable relation to the ordinary fees of the area for the service given, and should be arranged after consultation with the local profession.

(*d*) In every case an augmentation of salary or a suitable payment for mileage should be arranged, except when the practitioner's residence or consulting room is within two miles of the institution where the attendance or services are rendered.

The General Secretary said that the New South Wales Branch was not prepared to give services to those who could afford to pay. The Victorian Branch protested against any alteration in the present method. It disapproved of the abolition of the means test, and its members were not

prepared to treat patients in out-patient or indoor departments of hospitals unless a means test was operative. The South Australian Branch thought that the honorary system was destined to disappear. The Western Australian Branch was not prepared to treat patients without a means test, except in cases of emergency. The Queensland Branch thought that the honorary system should be abolished. The Tasmanian Branch reported that no means test was in existence in the State, and that, notwithstanding this, patients were treated by medical staffs acting in an honorary capacity.

Dr. W. F. Simmons said that the principle was important. New South Wales held strongly that if there was no means test, honorary service should not be given. In the Emergency Medical Service practitioners charged patients full rates as private patients—no evidence of indigency was required. Dr. C. Craig said that honorary medical officers undertook their duties for two kinds of reason. One group at teaching hospitals saw in honorary work a good deal of kudos and the value of teaching. The other group in non-teaching hospitals undertook the work because of its scientific value. The honorary officers did the work to learn their jobs. In Tasmania some specialists such as radiologists and ophthalmic surgeons were paid. Dr. F. L. Davies said that the question was enormous and that sight should not be lost of its implications. Among these were part-time clinics. Dr. H. R. R. Grieve said that the problem was one of the most difficult of those confronting the profession. It was not known which States would accept the Government's proposals, but it seemed that the means test would be abolished. He doubted whether the Federal Council could lay down a policy in the absence of definite knowledge. Dr. F. W. Carter said that he had gained the impression that there was some uncertainty in the official mind regarding the means test. Dr. W. F. Simmons said that some motion should be passed stating that no doctor should be asked to give honorary service to those who could afford to pay. Dr. C. Craig said that they ought to be careful about expressing such a view at the present time. The old hospital dispute in Tasmania had started because of a refusal of this kind. He thought it would be better to wait. Dr. H. C. Colville thought that some protest about the abolition of the means test should be voiced. After further discussion on the wording of the motion, it was resolved that no honorary medical officer should be expected to give honorary service to any patient who was able to pay for private and intermediate treatment.

The Pharmaceutical Benefits Act.

At its meeting in Sydney at the end of May, 1944, the Federal Council discussed the *Pharmaceutical Benefits Act* and resolved that it would not be a party to the act which it considered to be almost entirely without merit. It also drafted a statement which was to be sent to the Minister for Health stating that the Council could make no compromise on the principle that doctors working under the act should "remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way in which they feel to be the best". The statement continued that if the Government would accept the application of the principle enunciated by the Federal Council, a conference might be held to consider the clauses, other than those dealing with the formulary, with which the Council found itself in disagreement. At the conference with government representatives at Canberra in June the *Pharmaceutical Benefits Act* was discussed and an impasse was reached.

The General Secretary pointed out that the question would arise regarding the advice that should be given to members of the profession on the working of the act. The profession had not been told directly that doctors should not write on the form prescribed for the act or use the formulary. The General Secretary had thought that there might be a legal difficulty, that questions of conspiracy might arise if the profession was advised not to work under the act. The Federal Council's solicitors had replied that they could not see that the Council would be liable in any way whatever if it advised the profession not to cooperate with the Government. Dr. F. L. Davies thought that no concerted move should be made to prevent the use of the formulary. Many doctors had used the war formulary and become used to it. It was often useful. He thought that the practitioner should write the prescription on his own letterheads. Dr. W. F. Simmons pointed out that if the form was not used, the patient would not receive the benefit. Dr. H. R. R. Grieve said that when the question was raised in New South Wales regarding the advice to be given to practitioners, the reply was that they should prescribe for the patient according to his need and without any other consideration whatever. Doctors were not concerned with anything but medical science. If this attitude was adopted the formulary would not be used much. By and large the use of a formulary was unscientific. The physician who worked with a formulary ceased to use a number of drugs. To the expert physician this was a matter of some moment. Dr. Grieve said that he did not intend to prescribe according to the formulary unless asked to do so by the patient, and then only if he was satisfied that all was well. The Federal Council should determine what advice to give to members. He added that if drugs like sulphonamides could be obtained without cost to the patient, the doctor could not very well refuse. Dr. F. W. Carter was completely opposed to a formulary. The Federal Council should determine on a course of action. With this Dr. N. M. Cuthbert agreed and said that no hardship should be put up on the patient. Dr. A. E. Lee said that his difficulty was whether he had the moral right to refuse to write a prescription on the special form. He thought that he had no moral right to refuse. Dr. C. Craig thought that Dr. Grieve's attitude was sound, although its adoption might mean that the Federal Council was to a certain extent abandoning its position. The scientific side should be kept in view. Dr. C. Byrne said that if Dr. Grieve's advice was to be followed, it was a pity that they had ever opposed the act. They would say that to work under the act was immoral and unscientific and would proceed to use it. If members of the profession were not advised not to work under the act, they would do so in increasing numbers. Dr. Byrne thought that there should be a trial of strength; if this was not done, the profession would be giving the Government a green light in the matter of a medical service. Dr. W. F. Simmons and Dr. F. W. Carter agreed with Dr. Byrne. Dr. H. R. R. Grieve then said that he wanted to see the Government beaten and would agree to oppose the act if the majority wished this to be done. Dr. N. M. Cuthbert asked whether it would be advisable to wait. Dr. Colville agreed that it might be better to wait, otherwise the Council would be giving advice in regard to a publication which it had not seen. The difficulty could be got over by assuming that the formulary would not be a good one. It would perhaps be better to wait. Dr. Carter insisted again that the decision did not depend on whether the formulary was good or not; it depended on the use of a formulary in any circumstances. A formulary could give only a partial service. Dr. C. Craig agreed with Dr. Colville that it might be better to wait. The President referred to the previous determination of the Council to keep the whole question on the high plane of personal freedom, and not to be bound by the formulary at all. If the Council agreed to use the formulary it would be intellectually dishonest. Dr. H. R. R. Grieve said that if the Council asked the profession to wait, its members would think that the Council was unable to make up its own mind. He agreed that the use of a formulary was unscientific. Dr. A. E. Lee again raised his question of moral justification for refusal to use the formulary in certain circumstances. Dr. F. W. Carter said that it was a fight for a principle. It was impossible for anyone to abandon a principle without moral harm to himself. Dr. C. Byrne referred to the reasons against the use of the formulary, set out by the Victorian Branch, and said that they still held. There was an opportunity for the profession to defeat the Government. Dr. T. A. Price said that the profession would come in for criticism if its members condemned the formulary without seeing it, when they used formularies elsewhere. Dr. C. Craig said that he had changed his opinion and thought that the Council should take a stand. It was resolved on the motion of Dr. C. Byrne, seconded by Dr. F. W. Carter, that members of the Association should be informed of the nature of the objections of the Federal Council to the *Pharmaceutical Benefits Act*, and should also be advised not to cooperate with the Government in the use of the formulary on the prescribed forms.

Discussion then took place on the drawing up of a statement for transmission to the public. After perusal of a draft statement which was criticized from several points of view, Dr. H. R. R. Grieve was asked to draw up a statement. This he did, and later in the meeting his statement was adopted with one or two amendments in the following form:

> It will by now be known to members of the public at large that an act of the Federal Parliament called the *Pharmaceutical Benefits Act* has been passed, and that its provisions will soon be ready to be put into operation if the Government considers it proper and

desirable to do so. The public has doubtless given little consideration either to the main provisions of this act or to the repeatedly expressed unwillingness of the medical profession to assist in its workings. Yet, because this act would be so adverse in its effects on the individual patient, and because members of the medical profession are best qualified to perceive this adverse effect, the public should know more of it.

Now that provision of the act which most directly—and most adversely—concerns the people is this: that the patients will receive free of charge from the chemist the contents of any prescription by any doctor which is written in duplicate on prescribed, that is, special, forms, and which is contained within a formulary, that is, an official list of prescriptions compiled by a committee of seven appointed by the Government, two only of the members of which shall be practising doctors.

Now if this official list were wide open to every combination used by doctors, according to their judgement of the individual patient's need, there could be no reasonable objection to it on the ground that its use would prevent patients receiving their appropriate treatment, but this list is to be limited, and strictly limited, and the Government has repeatedly refused requests by representatives of the medical profession to allow it to include all combination of preparations considered necessary by the doctor. Accordingly, the medical profession, through its representatives, informs the public unhesitatingly that this main provision is opposed to the purpose of efficient medical treatment of sick people.

Why? Many of the combinations of preparations used in everyday treatment, let alone in less common treatment, will not be available free to the patient because they will not be in the formulary unless it be so enormous as to be impossible of practical use. Or, in other words, if the patient desired to obtain his prescribed treatment free, he would, in most instances, have to receive unsuitable treatment or treatment less than the best and most appropriate. Now there would, in many cases, be pressure on the doctor to prescribe treatment which the patient could receive free, and it is therefore certain that many patients would receive inferior treatment, unless doctors intimate that they are not prepared to use the official list. And doctors wish their patients now to know that they are not prepared to lower their efficiency, that they are not prepared to give their patients less than their best, that they are not, in their patients' interest, prepared to drift into a groove bounded by the narrow limits of a formulary, in other words, they are not prepared to use the official list of prescriptions called under this act a formulary.

Why does the Government insist on the use of a formulary for the purpose of this act? Why does it insist that the needy person will have to pay for his prescription unless it is in the list? The answer to these questions is provided by the Commonwealth Minister for Health in a statement submitted to representatives of the medical profession. "What may be considered the main drawback from the point of view of the medical profession is the adoption of a formulary as a basis for prescribing. This, however, has been found necessary in view of the requirements already outlined, and, also, because it considerably reduces the cost of administration by enabling the Government to offer chemists a satisfactory method of pricing without the necessity of introducing an expensive system of pricing each prescription."

So that, in the minds of the Minister and the Government, a method of pricing is more important than the patient's welfare.

There is a further decisive ground for objection to this act, and this concerns especially people resident in the country districts, though all would be to some extent adversely affected. Clause 22 of this act provides that a doctor is liable to heavy fine or imprisonment if he prescribes for a patient to secure treatment free under this act without examining the patient on each occasion in which a prescription is given. That provision means that no person could be prescribed for by telephone—and this is everyday practice in the country for reasons of urgency, convenience and the prompt relief of suffering—if he desired to have the right conferred by the act to freedom from charge for his prescription. That is mostly a thoughtless discrimination against the country resident.

The passing of the *Pharmaceutical Benefits Act*, as we have said, is probably a matter to which the public has given but little consideration. Yet the citizen should ask himself why the bottle of medicine should receive a priority in any scheme of medical services to the public. Surely it is better to spend public funds in the first place on the preventive side of medicine. For example, to see that all the people are adequately fed and educated in the proper use of food, or to make provision for the wiping out of tuberculosis. If, however, the treatment aspect of medicine is to be considered from the first, then let the money be spent on hospitals to provide all the buildings and equipment needed.

The medical profession in Australia is jealous of its general efficiency which entitles it to rank very high among those of the other countries of the world. It cannot therefore acquiesce in the operation of an act which will jeopardize that efficiency, an act in the drafting and preparation of which it, the most competent body in the Commonwealth, was not consulted, and in respect of which its advice has been consistently ignored by the Government. Nor will the profession readily permit the people to suffer from an act the weaknesses of which it feels in duty bound to expose.

It was resolved that a short statement should be drawn up setting out the objections of the Federal Council to the *Pharmaceutical Benefits Act*. This was done at the request of the meeting by Dr. H. C. Colville. It was adopted at a later stage when standing orders were resumed in the following form, the last two clauses having been drafted by Dr. F. W. Carter.

The Federal Council is opposed to the *Pharmaceutical Benefits Act*, 1944, for the following reasons:

1. The measure purports to provide a benefit to every member of the community, but in point of fact does not do so.

Under the provisions of the act the community will be divided into two sections—

(*a*) the individuals whose pharmaceutical requirements come within the limits of the official formulary and who will be entitled to the benefits of the act, and

(*b*) the individuals whose pharmaceutical requirements do not come within the limits of the formulary and who will not be entitled to the benefits of the act.

The Federal Council considers that this discrimination between individuals through circumstances over which they have no control is unfair to the public and entirely unjustifiable, and is not prepared to accept the responsibility of making, for every individual patient, the decision as to whether he is to be entitled to benefits or not. The fact that such a decision must be made on therapeutic grounds must inevitably lead to an interference with the age-old right and responsibility of the doctor to prescribe for his patient exactly what he thinks fit.

2. The measure lays down drastic penalties for doctors who carry out certain procedures in prescribing for patients; these procedures are not considered by the Federal Council to be incorrect, and it is therefore unwilling that doctors should be placed in a position where they may be unjustifiably penalized.

3. Objection is also taken to the form of administration which in the opinion of the Federal Council should be vested in a corporate body.

4. Objection is taken to the opportunity which it presents of introducing a nationalized medical service through an act not drawn up for that purpose.

Hospital Accommodation.

The General Secretary reported that a letter had been received from the New South Wales Branch in regard to hospital accommodation, and that another had come from the South Australian Branch in regard to the closing of private hospitals. He said that all the States were affected. The New South Wales Branch asked the advice of the Federal Council.

Dr. W. F. Simmons said that it was not a question of buildings. Hospitals had been forced to close because of a shortage of nursing and domestic staffs. The number of nurses in the services was in excess of the requirements. He thought that something might be done to secure the release of nurses for civilian work. Some of the hospitals

would reopen if nurses were made available. Dr. F. W. Carter said that the position in Western Australia was serious and that something should be done. Dr. H. R. R. Grieve said that the problem was becoming more and more acute. He thought that something in the way of a two-point policy should be suggested to the Prime Minister. In the first place releases should be made from the services, and in the second place the Government should be urged to build wards in each capital city on the pavilion system to make up for the acute shortage of beds. The pavilions if possible should be near existing hospitals, whose staffs might become responsible for them. Dr. George Bell endorsed Dr. Grieve's remarks and added that the shortage of nurses threw more work on doctors. Dr. F. L. Davies laid stress on the staff shortage in Victoria and said that it would become worse. After further discussion Dr. Grieve moved in accordance with the two-point policy that he had suggested. The motion was seconded by Dr. J. S. Reid and carried.

Resumption of Standing Orders.

At this stage the Federal Council resumed standing orders and considered the resolutions that had been adopted in committee. The decisions in regard to each of these will be stated in the subsequent sections of the report to which they belong.

Pharmaceutical Benefits Act, 1944.

The validity of the *Pharmaceutical Benefits Act*, 1944, was discussed in the light of a letter from the Victorian Branch. After discussion it was resolved that consideration of any action in the matter should be deferred.

The resolutions passed in committee in regard to the *Pharmaceutical Benefits Act* were formally adopted by the Federal Council. The statement for submission to the public has been reproduced in the report of the committee stage of the meeting; the amendments made by the Council in the statement of objections for submission to the medical profession have been included in the statement as printed above.

Medical Planning.

The Health Policy of the Australian Government.

The first six resolutions passed in the committee stage regarding the health policy of the Australian Government were formally adopted by the Federal Council. In the case of the second resolution, however, it was thought necessary to define the term formulation as follows: "Formulation is a term implying the stage that follows discussion and precedes implementation."

In regard to the resolution empowering Dr. Grieve to describe to the government representatives at the forthcoming conference the Metropolitan Hospitals Contribution Fund of New South Wales, it was resolved that any other methods of voluntary contribution that had been considered by the Council should be included.

The resolutions dealing with the taking of a report of the impending conference and with honorary service in public hospital wards were formally adopted.

The resolution in connexion with hospital accommodation was subjected to some verbal alterations and adopted in the following form:

> That this Council represents to the Prime Minister the necessity of dealing with the urgent need for increased hospital accommodation in accordance with the following two-point plan of short-term policy for the duration of the war:
>
> 1. Release of a proportion of trained nursing personnel from the armed services.
> 2. The making available of a number of hospital wards on the pavilion system in each of the main cities of the Commonwealth, preferably as adjuncts to existing hospitals.

Publicity.

The Federal Council had before it a draft brochure, drawn up by the General Secretary, dealing with a complete medical service and how it might best be attained, and intended for circulation among the general public. The brochure was adopted.

Expenses of Meetings Held at the Request of the Government.

The General Secretary reported that he had received from the Victorian Branch a letter suggesting that an approach should be made to the Federal Government in regard to reimbursement of the Federal Council in respect of expenses of meetings held at government request. All the Branches had agreed with the suggestion. The General Secretary said that the President had written to the Director-General of Health suggesting that the expenses of conferences held at government request should be paid for on the same scale as the allowances made to members of the National Health and Medical Research Council. The suggestion had been made that the holding of the impending conference in Melbourne would not involve extra expenditure, but it was pointed out that every extra day spent on the work of the Federal Council by the members meant more expenditure.

> That a request be made to the Government that when conferences are held at its request the expenses of representatives of the profession attending such conferences be paid by the Government at the same rate as that paid to members of the National Health and Medical Research Council.

Medical Planning in New Zealand.

The General Secretary brought to the notice of members the Final Draft Report of the Medical Planning Committee of the New Zealand Branch of the British Medical Association.

Report of the Council of the British Medical Association on a National Health Service.

The General Secretary drew the attention of the meeting to the *British Medical Journal* of May 13, 1944, containing a report of the Council of the British Medical Association to the representative body on a national health service, and also a draft statement of policy on the British Government White Paper.

The Parliamentary Joint Committee on Social Security.

The General Secretary reported that in accordance with a resolution of the Federal Council at its May meeting he had written to the chairman of the Parliamentary Joint Committee on Social Security asking that permission might be given for the publication in The Medical Journal of Australia of the report of the Parliamentary Joint Committee's Planning Committee. The chairman had given permission and the report was published in The Medical Journal of Australia of September 9, 1944.

The seventh interim report of the Parliamentary Joint Committee on Social Security was received.

The General Secretary reported that he had had a conversation with Mr. H. C. Barnard, the chairman of the Parliamentary Joint Committee on Social Security, regarding future conferences between that body and the Federal Council. The General Secretary thought that it was not possible for the Federal Council to negotiate with two bodies, and he did not think it likely that further conferences would be held.

Medical Planning Committee of the Federal Council.

The General Secretary said that copies of the report of the Medical Planning Committee of the Federal Council had been sent to the Branches, but no replies had been received.

Post-War Planning and the Nursing Profession.

The Federal Council considered a letter which it had received from the General Secretary of the Australian Nursing Federation urging that the British Medical Association should give full cooperation and support to the nursing profession in post-war plans.

The General Secretary pointed out that there were no less than eleven acts controlling nurses in Australia. The standards in the States were different and nursing organizations were not consulted in matters affecting nursing and the status of nurses. Nurses held that the control of nursing should be in the hands of nurses. The letter had been sent to the Branches. Four Branches had agreed that support should be given to the nursing profession. The South Australian Branch wished to know the plans of the Australian Nursing Federation, and the matter had not yet been considered by the New South Wales Branch. It was resolved that every support should be given to the Australian Nursing Federation in its post-war planning for the nursing profession.

War Emergency Organization.

Conditions of Service Committee.

Dr. F. L. Davies and Dr. H. C. Colville were reappointed members of the Conditions of Service Committee.

Repatriation Commission.

On many previous occasions the Federal Council had discussed the question of medical benefits for widows, orphans and widowed mothers of the present war. At the May

meeting it was pointed out that though the original arrangement to treat the dependants named in accordance with the terms of friendly society lodge agreements had been made for three months only, a period of more than three years had elapsed and the Minister for Repatriation had persistently refused to come to an agreement on the matter. At the May meeting it was reported that the only point in a proposed agreement to which the Minister would not consent was the clause requiring readjustment of the payment according to the basic wage index. It was then decided that the Minister for Repatriation should be informed that in view of the prolonged and unsatisfactory negotiations which had taken place, the tentative arrangement would be terminated as from June 30, 1944. The General Secretary reported that he had written to the Minister, and in reply had received a telegram from him asking the Federal Council to extend the present tentative arrangements to enable negotiations to be continued. The President had sent a telegram in reply stating that in his opinion the present serious position was entirely due to ministerial and repatriation procrastination and agreeing that the present arrangements should be continued for three months, conditionally upon consent to common form of agreement rates being given within three months. Two procrastinating replies had been received from the Minister, the first on July 10 and the second on September 14. In the latter communication the Minister had stated that the matter was still under consideration. On the Friday before the meeting the Minister had written yet again stating that there was not sufficient time before the end of the month (when the three month period of extension would expire) for him to come to a conclusion. He asked for an extension until June 30, 1945.

Dr. F. L. Davies moved and Dr. George Bell seconded the following motion which was carried:

> That a letter be sent to the Minister for Repatriation advising that, in view of the fact that the only point in dispute relates to the variation in the rate of payment in accordance with the variations in the Commonwealth wage index figure, the Federal Council is not prepared to grant any extension of the present temporary arrangement for the provision of medical services to the widows, orphans and widowed mothers of members of the armed forces killed in action or who die subsequent to their discharge and whose deaths are accepted as attributable to service in the present war, beyond September 30, 1944, and that this decision be also conveyed to the Minister by telegram immediately.

Dr. H. C. Colville said that he thought that further action should be taken. The department had dallied with the matter for four years or more and medical practitioners did not know the position. Dr. Colville thought that practitioners should be told that after September 30 no official arrangements would exist for the treatment of the persons in question and each practitioner might treat them as he wished. Dr. T. A. Price did not agree with what was suggested. It was finally resolved as follows:

> That members of the Association be advised that no agreement exists between the Federal Council and the Repatriation Commission for the provision of medical services to the widows, orphans and widowed mothers of members of the armed forces killed in action or who die subsequent to their discharge and whose deaths are accepted as attributable to service in the present war.

At the May meeting of the Federal Council consideration was given at the instance of the Western Australian Branch to the fact that medical officers of the Repatriation Department had no right to appeal against decisions of the Repatriation Commission—if a medical officer was censured the decision of the Commission was final. It was resolved at that meeting that consideration should be deferred pending the receipt of further information. The General Secretary reported that a letter had been received from the Queensland Branch dealing with the matter and expressing the view that the medical officer should have a right of appeal. After discussion it was resolved that the matter should be taken up with the Minister for Repatriation.

The Rehabilitation of Medical Officers in the Armed Forces.

At the May meeting of the Federal Council a good deal of discussion took place on the rehabilitation of medical officers in the armed forces. At the meeting three resolutions were adopted. In the first the Federal Council decided to inform the Central Medical Coordination Committee that the Federal Council wished to play the major part in the placement of medical service personnel in practice. The second resolution stated the view that the functions of the Central and State Medical Coordination Committees in the rehabilitation of service medical officers should be limited to priority of discharge and the arrangement of post-graduate studies and the finance thereof. In the third resolution the Federal Council expressed the opinion that in regard to their rehabilitation, medical officers from the armed forces should be entirely free to make their own decisions with advice and help from the State Medical Coordination Committees. The General Secretary said that he had written and had conveyed these resolutions to the Central Medical Coordination Committee. He had received a reply acknowledging receipt of his letter and asking the Association to define the part which it was prepared to play in the rehabilitation of medical officers, and to indicate the resources which it had proposed to establish in order to carry out any system of placement of these officers.

Copies of the Central Medical Coordination Committee's letter had been sent to the Branches. The Queensland Branch had replied that it was in a position to undertake a major role. It had a subcommittee formed; a post-graduate committee was active and was arranging refresher courses; and "Medical Finance" funds were available. The Tasmanian Branch had replied that it approved the principles enunciated by the Federal Council and was prepared to set up a committee to advise medical officers, but it was not quite clear about finance. Dr. F. W. Carter said that the Western Australian Branch had considered the question. It hoped to be able to finance men in the purchase of or part payment for practices. It had occurred to them in Western Australia that every practitioner under sixty years of age was under control and would remain under control for six months after the war. Demobilized men would be under the control of the coordination committees and might be transferred to a salaried service. This uncertainty made it unlikely that any financial institution would lend money to these men. The ability to use funds of an organization like "Medical Finance, Limited", depended on the existence at the end of the war of a stable state of the profession. The position therefore would have to be clarified. Dr. W. F. Simmons said that in New South Wales future action depended on the fate of the profession—the whole question of loans depended on the state of post-war practice and of the profession. In the circumstances "Medical Finance" might not be able to do a great deal, but it was the duty of the Branches to see to the welfare of their men. The President pointed out that an answer had to be given to the Central Medical Coordination Committee. Dr. George Bell said that in his capacity of chief executive officer of the New South Wales State Coordination Committee he had written to the New South Wales Branch. The Branch was trying to find out what men could be placed in certain towns and districts, hospitals had been written to and so on. The Newcastle district, for example, could absorb forty men. Dr. A. E. Lee said that in Queensland the Committee of the Branch Council was working in collaboration with the State Medical Coordination Committee. Queensland was fortunate in that all its practitioners were not enrolled in the Emergency Medical Service. Dr. N. M. Cuthbert asked why the Central Medical Coordination Committee wanted to know what the Association's resources were, and the President replied that it was a natural question to ask. Dr. George Bell said that it was a most important question. It might be necessary for practitioners to put their hands into their pockets as they had done when men joined the services. Dr. F. L. Davies asked whether the Central Medical Coordination Committee could give any idea of the date at which men would be discharged from the services. The General Secretary did not think that it was possible at that stage to answer the Central Medical Coordination Committee's letter. The President suggested that the reply might be that no detailed information was yet available, but that efforts were being made to obtain it. Dr. H. C. Colville suggested that there might be an element of urgency. A somewhat false position had been created. As a result of the profession's delay some injustice might be done. The authorities had some ideas on the subject and the Federal Council had created the impression that the British Medical Association would relieve them of some of their responsibilities. Unless the Federal Council could amplify its statement, the statement should be withdrawn so that the men concerned would receive fair treatment. The President said that all the Branches were active and were impressing on their members the importance of the whole question of rehabilitation. It was resolved

that the General Secretary should answer the letter of the Central Medical Coordination Committee and state the position.

The Queensland Branch wrote regarding the rehabilitation of medical officers while remaining in the services. It asked that medical officers whose units were staging should have opportunities for post-graduate work, and also that hospital experience should be provided for medical officers by rotation of appointments. The General Secretary explained that the Queensland Branch had written to the Central Medical Coordination Committee on the matter and that the committee had replied that the medical directors of the services had considered the question and that when facilities were available and when opportunity offered, clinical work was provided and that the interests of medical officers were not overlooked. After discussion it was resolved that the Federal Council should ask its representative on the Central Medical Coordination Committee to bring to the notice of the services directors the desirability of medical personnel in the units staging being granted facilities in service hospitals for post-graduate instruction.

At the May meeting of the Federal Council a proposal was made that steps should be taken to publish each week in THE MEDICAL JOURNAL OF AUSTRALIA a list of medical men who had been released from full-time duty with the armed forces, together with their addresses and the dates on which private practice was to be or had been resumed. The General Secretary reported that he had, as directed, taken up the matter with the directors of the Australasian Medical Publishing Company, Limited, and that such a list was being published from time to time at the request of the practitioners concerned.

The Medical Attendance on Members of the Military Forces by Civilian Practitioners and the Payment of Mileage.

At previous meetings of the Federal Council consideration had been given to the payment of mileage or of a travelling allowance to civilian practitioners who were called on to attend members of the military forces at a distance. The rates payable, which varied from fivepence to eightpence a mile, according to the horsepower of the practitioner's motor-car, were held to be quite inadequate. It was held that the fees payable should be those operating in the Emergency Medical Service, and it was pointed out in the discussion that no allowance was made for the practitioner's time. The General Secretary reported that in accordance with the decision of the May meeting of the Federal Council, he had written to the Minister again and that he had replied stating that a decision on the matter would be made at the earliest possible moment. So far no further advice had been received.

The Shortage of Civilian Medical Practitioners.

The General Secretary reported that on May 30, 1944, he had written to the Central Medical Coordination Committee regarding the shortage of civilian medical practitioners, pointing out that the numbers available were quite insufficient to meet the needs of the situation and recommending the release of more service personnel. A reply had been received. In this reply it was pointed out that when release of a medical officer was recommended, the recommendation was sent to the director-general of the service concerned. The director-general considered the recommendation and gave a decision which was communicated to the State Medical Coordination Committee. If the State Committee wished, it might ask for a decision to be reconsidered; the director-general alone could determine whether a medical officer could be spared—the needs of the services were paramount. It was also stated that during the twelve months ended April 30, 1944, medical officers had been released from all three services (the numbers were given). The numbers of those called up for these three services were also stated; of those called up all were recent graduates. The requests for medical officers for civilian practice were always sympathetically received.

Shortage of New Motor-Cars.

At the May meeting of the Federal Council the shortage of new motor-cars was considered together with a previous recommendation to the Minister for Supply that an effort should be made in the interests of the sick public to secure motor-cars that are necessary for the conduct of medical practice. On that occasion consideration was deferred pending the receipt of further information by the General Secretary. The General Secretary reported that the situation was still difficult. He explained that very few new motor-cars would be available in New South Wales and that these had to be fitted with bodies. Also several motor-cars that had been used by the American Army had been reconditioned and might become available. There was not much hope that the situation would be relieved.

Shortage of Junior Resident Medical Officers in Western Australia.

At the May meeting of the Federal Council the shortage of junior resident medical officers in Western Australia was considered and it was resolved that the matter should be left in the hands of the representative of the Federal Council on the Central Medical Coordination Committee. The General Secretary reported that representations had been made to the committee, and that a reply had been received stating that the executive officer of the Western Australian committee had written to the Central Medical Coordination Committee on the matter. This officer had stated that with the arrival of two graduates from South Australia the numbers required by Western Australia should be complete. The position was that Western Australia asked for fifteen graduates, and that with the two who were coming from South Australia it would receive sixteen, an additional graduate having been supplied from Victoria because one of those sent from that State was a sick man. The letter was received.

Rationing.

A letter from the Western Australian Branch was read dealing with the subject of food rationing for expectant mothers. At a public meeting held in Perth and arranged by the Provisional Council for the Implementation of the Australian Women's Charter (Western Australian Section), a resolution was carried suggesting that the Federal Government should be asked to provide for expectant mothers special rationing permits for fish, cheese, eggs and meat, these foods being difficult to obtain in Western Australia and sometimes unprocurable. Dr. W. F. Simmons, the representative of the Federal Council on the National Health and Medical Research Council, referred to the work of the diets committee of that council and to the difficulties connected with food rationing. It was resolved that the matter should be left in the hands of Dr. Simmons as the Federal Council's representative on the Food Rationing (Special Diets) Committee of the National Health and Medical Research Council.

The Federal Council also had before it some correspondence with the Victorian Branch and with the chairman of the Food Rationing (Special Diets) Committee of the National Health and Medical Research Council on the subject of the butter ration for diabetics. The latter had stated that the reduction was only temporary and should not tax the ingenuity of medical officers because other fats were available. In discussion it was pointed out that the proportion of diabetics in the community was not known. It was also remarked that no member of the Special Diets Committee would like to have to take six ounces of dripping every week. Moreover, diabetics could not take honey, jams or sugar to provide variation. Dr. W. F. Simmons said that the Special Diets Committee was alarmed at the number of diabetics in Sydney—over seven thousand. The accuracy of this figure was questioned and the statement was made that the number in New York was not nearly so large. In spite of the high number of diabetics in Sydney, it was curious that most complaints came from Melbourne. In Sydney there had been no lard for two years. Moreover, dairy farmers were responsible for the small amount of margarine that was obtainable—they had fixed the amount to be manufactured in relation to the amount of butter that was available. Dr. A. E. Lee pointed out that no planting of peanuts was being allowed in the Kingaroy district. The correspondence was received.

The Fees of Locum Tenentes.

A letter was received from the Queensland Branch stating that the fees of *locum tenentes*, recommended by the Federal Council to range from twelve to fourteen guineas a week, had been fixed by the Queensland Branch at fourteen guineas in order to be the same as the fee payable in the Emergency Medical Service.

Income Tax Deductions and Amounts Paid to War Benefits Funds.

At the May meeting of the Federal Council further reference was made to a decision of the Income Tax Commissioner regarding amounts contributed by medical officers to war benefit funds. The Commissioner ruled that when practitioners were employees the amount of their contribu-

tions could not be allowed as income tax deductions. It was decided at that time that the only remedy lay in an amendment of the act, and it was resolved that an approach should be made to the Federal Treasurer. The General Secretary said that this had been done and he read the Treasurer's reply as follows:

> With further reference to my letter of June 27, 1944, I have discussed the matter raised by you with the Commissioner of Taxation and, after consideration, have come to the conclusion that I should not be justified in proposing to amend the *Income Tax Assessment Act* in the way you suggest.
>
> My principal reason is that members of your profession who are in employment cannot be regarded as being on the same footing as those who are practising independently, in relation to the pooling of income for the benefit of members who are on active service.
>
> Section 102AA, so far as your Association is concerned, acknowledges the existence of a state of affairs in which, owing to the departure of certain of your members on active service, the income of the other members who remain behind has been very substantially increased, and the recipients of the increased income have endeavoured to divest themselves of at least a part of the fortuitous advantage so obtained. The section is, in effect, a contribution to the working out of a thoroughly equitable scheme.
>
> Your members who are in employment, however, have not received any advantage of the essential kind which I have mentioned, and any contributions made by them to the pool cannot be reasonably regarded as anything but benevolences.

The letter was received.

The Australian Council of Organization for Relief Abroad.

The General Secretary presented a copy of the constitution of "UNRRA", the Australian Council of Organization for Relief Abroad, which had been received from the Secretary of the Department of External Affairs. The document was received.

Federal Medical War Relief Fund.

A letter was received from the New South Wales Branch inquiring whether any action had been taken by the Federal Council to establish a Federal Medical War Relief Fund. The General Secretary said that he had received a legal opinion regarding taxation to the effect that as far as could be seen such a fund would not be subject to taxation after the war. An inquiry had been sent to the Commissioner of Taxation, who had replied that the fund would be regarded as a charitable fund if it was available to all medical practitioners and not exclusively to those who were members of the British Medical Association. After discussion it was resolved that a Federal Medical War Relief Fund should be established and that its objects should be as follows:

> (*a*) To assist members of the medical profession who have been disabled and the dependants of those who have died as a result of enemy action or of sickness contracted while serving in the armed forces.
>
> (*b*) To issue loans with or without interest to medical men who, as a result of enemy action, may require temporary financial assistance.
>
> (*c*) The fund be established by donations from members of the profession in all of the States, and to commence the fund an effort be made in each State to secure at once as large initial donations as possible.
>
> (*d*) The fund to be controlled by the Federal Council.
>
> (*e*) A local committee of management to be appointed by the Branch Council in each State consisting of three members of the British Medical Association.
>
> (*f*) The Federal Council to have the power to use any surplus funds for the purposes of medical benevolence.

It was resolved that a letter, under the signature of the President, should be sent to every member of the profession in Australia inviting contributions to the fund.

Medical Research in Australia.

The President having raised the question of medical research in Australia and the desirability of having an organization devoted solely to the control of research, Dr. W. F. Simmons said that medical research should be controlled by a separate body. His experience as a member of the National Health and Medical Research Council had led him to this conclusion. The personnel of the committee which made decisions regarding grants and equipment was not comparable to that of the Medical Research Council of Great Britain. The visit of Sir Howard Florey to Australia and the opinion on research in Australia that he had voiced, together with views expressed in public by Sir Alan Newton, were important. The council that was needed should comprise hand-picked men with a wide outlook. Private benefactions for medical research would not be forthcoming while it was controlled by a government department. After discussion it was resolved as follows:

> That the interests of the public and of medical science in Australia would be best served by the creation of a Medical Research Council.
>
> That this decision be conveyed to the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians and to the Australian universities.

Matters Deferred.

Consideration of the following matters was deferred: the Federal Emergency Compensation Fund, public medical services and the principles of medical ethics.

Report of the Committee on the Conference with Government Representatives.

The committee appointed to meet the government representatives to discuss with them the health policy of the Commonwealth Government presented its report to the Federal Council on September 28, after the conference. It was reported that a frank exchange of views took place, but that no decisions had been reached on matters of policy. A short statement was drawn up by the conference for presentation to the Federal Council. This statement has not been made available to this journal; it is understood that its contents will be conveyed to members by the Branch councils. The statement was formally received by the Federal Council and the members of the committee were thanked for their services.

It was resolved that the resolutions embodied in the instructions to the committee prior to the conference should be adopted as the policy of the Federal Council in future discussions with the Government in connexion with a possible government medical service, until such time as they were added to, replaced or amended by the Federal Council.

Date and Place of the Next Meeting.

The date and place of the next meeting were left in the hands of the President.

Votes of Thanks.

Votes of thanks were passed to the Victorian Branch Council and to Dr. F. L. Davies and Dr. H. C. Colville for their hospitality, and to the Victorian Branch for the use of its offices.

The thanks of the Council were also extended to the President, Sir Henry Newland, for presiding.

NOTICE.

THE General Secretary of the Federal Council of the British Medical Association in Australia has announced that the following medical practitioner has been released from full-time duty with His Majesty's Forces and has resumed civil practice as from the date mentioned:

Dr. Norman Sherwood, Ballow Chambers, Wickham Terrace, Brisbane (October 16, 1944).

Post-Graduate Work.

A FILM EVENING AT SYDNEY.

THE New South Wales Post-Graduate Committee in Medicine announces that a film evening will be held at 20, Chalmers Street, Sydney, at 8 o'clock p.m. on Wednesday, November 15, 1944. The title of the Air Force film to be shown is "Neuropsychiatry". There will be no charge for admission and cards may be obtained from the Secretary of the Post-Graduate Committee, 145, Macquarie Street, Sydney, telephone B 4606. As attendance will be limited, these cards will be made available only to the first sixty applicants.

The Royal Australasian College of Physicians.

EXAMINATION FOR MEMBERSHIP.

THE following candidates, who were successful at an examination for membership of the Royal Australasian College of Physicians held in Sydney and Melbourne in August-September, 1944, have been admitted to membership at recent meetings of the Council: Squadron Leader J. M. Alexander, Captain G. M. Blaxland, Major R. G. B. Cameron, Major R. J. Hoy and Major J. F. McCulloch, of New South Wales; Wing Commander G. J. B. Baldwin, Group Captain P. J. Benjamin, Major J. E. Clarke, Major J. E. Grice, Major H. B. Kay, Major W. E. King, Captain George Reid, Dr. H. J. Sinn, and Lieutenant-Colonel S. W. Williams, of Victoria; Major F. R. Magarey, Major John Ray and Dr. E. B. Sims, of South Australia; Major V. J. McGovern, of New Zealand.

Obituary.

ARTHUR PLUMBE.

WE regret to announce the death of Dr. Arthur Plumbe, which occurred on October 3, 1944, at Mosman, New South Wales.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Gibson, Lloyd Cameron, M.B., B.S., 1943 (Univ. Sydney), District Hospital, Wollongong.

Kennett, Arthur Lloyd, M.B., B.S., 1939 (Univ. Sydney), "Hazelwood Park", Glenfield.

Protopopoff, Nicholas Paul, M.D., 1917 (Odessa, Russia), 104, Australian General Hospital, Bathurst.

Ardill-Brice, Katie, M.B., Ch.M., 1913 (Univ. Sydney), 215, Macquarie Street, Sydney.

Pilcher, Robert Bruce Minter, M.B., B.S., 1939 (Univ. Sydney), 16 Australian Camp Hospital, Ingleburn.

Howse, Neville Beresford, M.B., B.S., 1942 (Univ. Sydney), 68, Sampson Street, Orange.

Lazarus, Keith Joseph, M.B., B.S., 1943 (Univ. Sydney), 9, March Street, Bellevue Hill.

Medical Appointments.

Dr. Herbert Berkeley Deane Vaughan has been appointed Quarantine Officer at Portland, Victoria.

Dr. John Flynn has been appointed Quarantine Officer at Bunbury, Western Australia.

Dr. Godfrey James Byrne has been appointed Deputy Quarantine Officer at Gladstone, Queensland.

Books Received.

"Textbook of Surgical Treatment including Operative Surgery", edited by C. F. W. Illingworth, M.D., Ch.M., F.R.C.S.E., compiled by nineteen contributors; Second Edition; 1944. Edinburgh: E. and S. Livingstone Limited. 9½" × 6", pp. 576, with many illustrations, some of which are in colour. Price: 30s. net.

"Surgery of Modern Warfare", edited by Hamilton Bailey, F.R.C.S.; Sub-Editor for Medicine: C. Allan Birch, M.D., M.R.C.P., D.C.H., D.P.H., M.M.S.A.; compiled by seventy-seven contributors; Part VI; Third Edition (complete in six parts); 1944. Edinburgh: E. and S. Livingstone Limited. 8½" × 5½", pp. 897-1108, with many illustrations, some of which are in colour. Price: 15s. net.

"The Diabetic ABC: A Practical Book for Patients and Nurses", by R. D. Lawrence, M.A., M.D., F.R.C.P. (London); Eighth Edition with Wartime Supplement; 1944. London: H. K. Lewis and Company, Limited. 8½" × 5½", pp. 76. Price: 4s. net.

Diary for the Month.

Nov. 1.—Victorian Branch, B.M.A.: Branch Meeting.
Nov. 1.—Western Australian Branch, B.M.A.: Council Meeting.
Nov. 2.—South Australian Branch, B.M.A.: Council Meeting.
Nov. 3.—Queensland Branch, B.M.A.: Branch Meeting.
Nov. 3.—Victorian Branch, B.M.A.: Legislative Subcommittee.
Nov. 7.—New South Wales Branch, B.M.A.: Organization and Science Committee.
Nov. 10.—Queensland Branch, B.M.A.: Council Meeting.
Nov. 13.—Victorian Branch, B.M.A.: Hospital Subcommittee.
Nov. 13.—Victorian Branch, B.M.A.: Finance Subcommittee.
Nov. 14.—Victorian Branch, B.M.A.: Organization Subcommittee.
Nov. 14.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
Nov. 14.—Tasmanian Branch, B.M.A.: Branch Meeting.
Nov. 15.—Western Australian Branch, B.M.A.: Branch Meeting.
Nov. 16.—Victorian Branch, B.M.A.: Executive Meeting.
Nov. 16.—Victorian Branch, B.M.A.: Ethics Subcommittee.
Nov. 16.—South Australian Branch, B.M.A.: Council Meeting.
Nov. 21.—New South Wales Branch, B.M.A.: Medical Politics Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

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